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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13689

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before ad a. STATE Maryland b. COUNTY Frederic C. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest towns) C. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest towns)					laryland	Tre	der	ick V	
b. CITY OR TOWN write RURAL of Rural ST	(If autside carparate limits, and give negrest tawn)		LENGTH OF STAY IN 16	c. CITY OR TOWN (If a			RAL and give	nearest	tawn)
d. NAME OF HOSP	ITAL OR INSTITUTION (If not i	n haspital, give		d. STREET ADDRESS			158		IS RESIDENCE ON A FARM?
	ld State Hos	brrar		Box 57	T				ES NO
3. NAME OF DECEASED (Type or print)	First Mary		Middle Agnes	Barthel	4. DATE OF DEATH	Mant 1		Day 8	Year 19 67
S. SEX		. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	-	AGE (In years	IF UNDER 1		IF UNDER 24 HR
female	white	WIDOWED 🛣	DIVORCED	12/15/91		birthday) Yrs.	Manths	Days	Haurs Min
10a. USUAL OCCUPATIO during most of working	ON (Give kind af wark dane og life, even if retired) VOLK	10b. KIND INDUS	OF BUSINESS OR TRY	11. BIRTHPLACE (Count New Yor		ign country)		IZEN OF JNTRY?	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN	NAME				
John Woo	ods			Degogook	Bridg	et Gart1	and		
1S. WAS DECEASED E (Yes, na, ar unknawn	VER IN U.S. ARMED FORCES? (If yes give war ar dates af s	ervice		ningfield H	ospital	Addre		cosv	ille,Md
Canditions, if ar rise ta immedi stating the und	DUE TO (b) are cause (a), elerlying cause (c)			cardiovascul					
-	significant conditions con brain syndr						react		WAS AUTOPSY PERFORMED?
= 20a. ACCIDENT W	AS UNDERLYING G CAUSE OF DEATH	20b. DESCRI	BE HOW INJURY OCCURRE	D. (Enter nature af injury in	Part I ar Part	11 af item 1B.)			
	Y MEDICAL EXAMINER)								
20c. TIME OF IN	JURY Manth, Day, Year	20d. INJUR While at wark	Nat While	PLACE OF INJURY (Hame, fa factory, street, affice bldg., et		(City ar tawn)	(Cau		(State)
20c. TIME OF IN Hour of sow the	JURY Manth, Day, Year o.m. 19 tify that (this hospit deceosed olive on	While at wark	Nat While at wark the deceased from	factary, street, affice bldg., et	19 66 to	10/8	/, 1%1 ond on th	Z , the	ot 🗷 (we) le
20c. TIME OF IN Hour of	JURY Manth, Day, Year o.m. 19 tify that (this hospit deceosed olive on	While at wark	the deceosed from	y 114/, hot deoth occurred of M.D. PHYS.	19 66 to	10/8	, 19 6 7 ond on th	7 . the	ot (we) le stoted obo
20c. TIME OF IN Hour of sow the	UURY Manth, Day, Year a.m. 19 tify that (this hospit deceosed olive on E	while at wark [tol) ottended 10/8/	the deceosed from	factory, street, affice bldg., et 9/114/, hot deoth occurred o	MED. DIRECTOR [10/8	/, 1% ond on th 22b. DA 10,	Z, the dote tresigne /9/6	ot (we) les stoted obor
20c. TIME OF IN Hour of the sow the 22a. SIGNATUR 22c. PHYSICIAN NAME (Typ. 23a. BURIAL, CREMA	JURY Manth, Day, Year J.m. 19 tify that (this hospit deceosed clive on	While at wark Col) oftended 10/8/	the deceosed from 19 67, ond to M. D. 33. NAME OF CEMETERY (factory, street, affice bldg., et 9/11/ , hot deoth occurred of M.D. ATTENDING PHYS. 22d. ADDRESS DR CREMATORY	MED. DIRECTOR ESPICES 23d. LOC	10/8 Ifom couses STAFF PHYS. Field S Fille, M ATION (City or To	ond on the 22b. DA 10, tate I arylar	7, the dote the signal of the	ot (we) los stoted obove 77
20c. TIME OF INHOUSE TO SOW the 22a. SIGNATUR 22c. PHYSICIAN NAME (Typ.	UURY Manth, Day, Year a.m. 19 tify that (this hospit deceosed olive on E See) Carlos (100, 23b. DATE THERE 10/11/6	While at wark Col) oftended 10/8/	the deceosed from 19 67, ond to M. D.	m.D. ATTENDING PHYS. 22d. ADDRESS OR CREMATORY Cemetery	MED. DIRECTOR ESPICES 23d. LOC	10/8 If of the courses of the courses of the courses of the courses of the course of t	ond on the 22b. DA 10, tate I arylar	7, the dote of the signal of t	ot (we) stoted obcomposites (State)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. at Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician. O HOSPITAL

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13586 11.146.916) CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY CARROLL Maryland MARYLAND Washington c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) 11 yr. 2 mo.6 da Hagerstown e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS SPRINGFIELD STATE HOSPITAL p in 713 Maryland Avenue NO 3 3. NAME OF First Middle 4. DATE Month carbon Lost Year DECEASED DONATO NMN BASTLE (Type ar print) DEATH 10 16 19 67 IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH AGE (In years 7. MARRIED last birthday) Months Haurs 11/29/1884 WIDOWED DIVORCED gud 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 1st papers during most of working life even if retired) cement mfg. Italy 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaval, Stephen Basile Marie F. attending paramit. The IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes give wor or dates of service) ь Springfield State Hospital Records 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit burial, cremati PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Bleeding gastric ulcer IMMEDIATE CAUSE (o) DUE TO Canditions, if ony, which gove Bronchopneumonia days rise to immediate couse (a), DUE TO stating the underlying cause Arteriosclerotic heart disease vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) reaction 19. WAS AUTOPSY PERFORMED? CBS assoc. with circulatory distb. with cerebral art. with psychotic YES X certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (Stote) 20c. TIME OF INJURY Month, Dov. Yeor (City or tawn) (County) Hour o.m. foctory, street, affice bldg., etc.) Not While of work **DIRECTOR:** After be retained by 21. I certify that (1) (this hospital) attended the deceased fram 8/10/56 . 19 __, that (I) (we) last saw the deceased glive an 120/16/67 19 ____, and that death occurred at_ M. fram causes and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. be filed 22d ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Isaac E. Hapner, M.D. directar, shauld be 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) bully (pecify) 10-19-67 Rose Hill Cemetery Hagerstown, Md. 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 man

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1	. PLACE OF OEATH o. COUNTY					utian: Residence befare admission)	
	C.	ARROLL	MARYLAND			lllegany	
	b. CITY OR TOWN write RURAL or	(If autside carparate limits, nd give nearest tawn)	c. LENGTH OF STAY IN 1b		autside carparate limits, write R	URAL and give nearest tawn)	
-			lyr 11 mo	d. STREET ADDRESS	stburg	O/-	1
		TAL OR INSTITUTION (If not in				e. IS RESIDEN	
=	. NAME OF	ield State Hos	Middle	Lost Lost	ain Street 1 4 DATE Mg	nth Day Year	130
ľ	OECEASED (Type or print)	JAMES	GORDON	BEEMAN	OF	nth Day Year 26 19 6	7
5	. SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years	IF UNDER 1 YEAR IF UNDER 24	HRS.
	Male	W	VIDOWED DIVORCED	02/22/12	last birthdoy) yrs.	Manths Days Haurs 1	Min.
	0o. USUAL OCCUPATIO	N (Give kind of work done	10b. KIND OF BUSINESS OR		y & Stote, or foreign country)	12. CITIZEN OF WHAT	
	Laborei	C C C C C C C C C C C C C C C C C C C	STATE ROADS	Maryl		COUNTRY A.	
	3. FATHER'S NAME			14. MOTHER'S MAIDEN			
		el Beeman			Table Horton		
	(Yes, na, ar unknawn)	ER IN U.S. ARMED FORCES? (If yes give war ar dotes af ser		17. INFORMANT		ress	
				Springileic	d Hospital Rec		
		DEATH (Enter anly ane cause po NTH WAS CAUSED BY:				INTERVAL BETWEE ONSET AND DEAT Davs	
	4200	IMMEDIATE CAUSE (a) _	Confluent brond	chopneumon1a		Days	
1	Canditions, if any	DUE TO	Arterioscleroti	e heart dise	256	Years	
ı	rise ta immedia	te cause (a),	AT OCT TODOTICE OF	to near o arbo			
1	stating the under	eriying couse (c)					
	PART II. OTHER S	IGNIFICANT CONDITIONS CONTR	IBUTING TO DEATH BUT NOT RELATED	TO THE TERMINAL DISEASE CO	ONDITION GIVEN IN PART 1(a)	19. WAS AUTOPS	
ATIO	CBS ass	soc. with cere	ebral arterioscle	rosis with be	ehavioral reac	etion PERFORMED?	
CEDITICION			20b. DESCRIBE HOW INJURY OCCURI				
MEDICAL	2Dx. TIME OF INJ Hour o.	JURY Manth, Day, Yeor m. 19	20d. INJURY OCCURRED 2De. While Not While of work of work	PLACE OF INJURY (Hame, far factory, street, affice bldg., etc		(Caunty) (Stat	te)
	saw the d	leceased alive an 10/) attended the deceased fram 26 19 67, and	$\frac{11/12}{}$, that death accurred a	19 65, to 10/26 t 8:15 PM, from causes	2/, 19 <u>67</u> , that (I) (we s and an the date stated a) lo bav
	22a. SIGNATURE	elfredo n	Lacuit	M.D. ATTENDING PHYS.	MED. STAFF DIRECTOR PHYS.	22b. DATE SIGNED 10/26/67	
	22c. PHYSICIAN': NAME (Type	Alfredo M.	Labrit, M. D.	22d. ADDRESS Springf:	ield State Hos	pital	
2	3a. BURIAL, CREMATI				23d. LOCATION (City or T	, , , , ,	
E	UREMONAL (Specif	OCT.29,	1967 FROSTBURG		FROSTBUR		ND
1	AND ENNERAL ONE CL	M. SOWEBS, HA	FERNSON FROM BUX	WERAL HOME	OCT 3 1 1967	REGISTRAR'S SIGNATURE YCUSHLAS UM	10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours Poge 4 may be retained by the hospitol or attending physician.

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TO FUNERAL RECTOR: After this certificate has been signed by the attending physician and complicator, page 3 should be detached for use as the burial-transit permit. Then please removel carbon be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, withing

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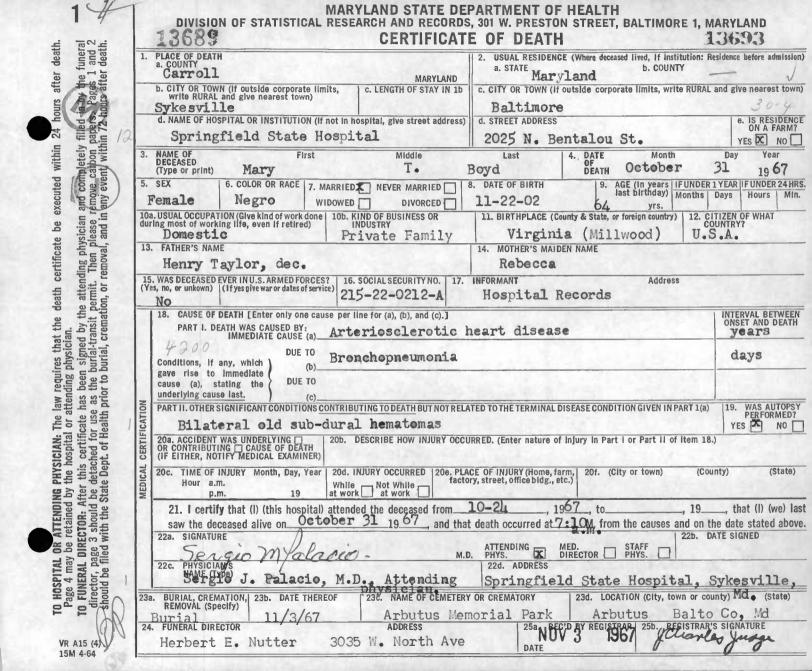
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 13683

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- 1		
	1. PLACE OF DEATH a. COUNTY CAROLL MERVLEND	e. STATE Md. b. COUNTY Balto.
	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1	write RURAL, and give nearest town) Westmunster	Owings Mills
0	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give straet eddrass) (arroll (ounty General Hospt.)	d. STREET ADDRESS 11137 Reisterstown Road 6. IS RESIDENCE ON A FARM? YES \(\text{NO} \) NO \(\text{NO} \)
	3. NAME OF First Middle DECEASED	Last 4. DATE Month Day Year
	(Type or print) Edith	Bosley DEATH /0 14 1967
		P. AGE (In years of Juntier 1900) 9. AGE (In years of Juntier 1900) 9. AGE (In years of Juntier 1900) 1. AGE (In years of Juntier 1900) 2. AGE (In years of Juntier 1900) 3. AGE (In years of Juntier 1900) 3. AGE (In years of Juntier 1900) 4. AGE (In years of Juntier 1900) 5. AGE (In years of Juntier 1900) 5. AGE (In years of Juntier 1900) 5. AGE (In years of Juntier 1900) 6. AGE (In years of Juntier 1900) 6. AGE (In years of Juntier 1900) 7. AGE (In years of Juntier 1900) 7. AGE (In years of Juntier 1900) 8. AGE (In years of Juntier 1900) 9. AGE (In years
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (mployed at Landray	11. BIRTHPLACE (County & Stata, or foraign country) Balto. (o. Md. USA
	13. FATHER'S NAME Noah A. Bosley	14. MOTHER'S MAIDEN NAME Violet Harris
	(Yes, no or unknown) (Ifvergive war or deterotranica)	s. Lillian G. Baublitz Owings Mills, Md.
	1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lest. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] DUE TO DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lest.	
2		OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED?
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO DIAGRAPH CONTRIBUTING TO DEATH BUT NO 208. ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCURED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	. (Entar natura of injury in Part I or Pert II of itam 1B.)
		CCE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ory, straat, offica bidg., atc.)
		death occured at E. A., from the causes and on the date stated above.
-	22a. SIGNATURE	ATTENDING MED. STAFF PHYS. 22b. DATE SIGNED 22b. DATE SIGNED 22d. ADDRESS
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY (REMOVAL ISpecify) Oct. 17.67 Wesley (eme	OR CREMATORY 23d. LOCATION (City, town or county) (State) etery. (arroll (o. Md.
	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. F. Eline & Sons Reisterstown, Md.	250. POCIOTY PEOPSTRAS BYD. RECISTIVAR'S SIGNATURE OF THE DATE

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13690 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

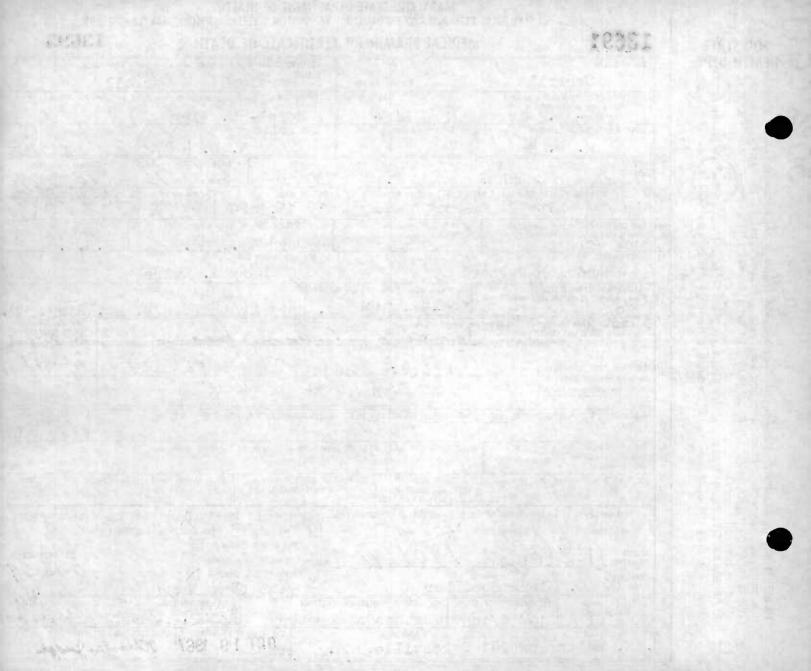
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3. MANE OF DECLARD (1998 or print) BERNARD BELL BROOKS RECORD RACE 7. MARRIED White Whowe Whowe Whowe Who of powers Mane White Who of powers Month Doy Year Yes Mane RELL ROOKS RECORD ROOKS RECORD ROOKS RECORD ROOKS RECORD ROOKS RECORD Rooks Roo	1											_	
b. CITY OR ROWN (It outside corporate limits, write RURAL and give nearest town) SYRES (ILLE) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) SPRINGFIELD STATE HOSPITAL d. STREET ADDRESS SPRINGFIELD STATE HOSPITAL Middle D. STATE HOSPITAL BELL BROOKS BERNARD BELL BROOKS A DATE BROOKS BERNARD BELL BROOKS BEATH LO 29 1667 S. SIX 6. COLOR OR RAGE 7. MARRID MILL MIDDRESS NO 18 BENNARD BELL BROOKS BEATH LO 29 167 S. SIX MALE White Whowe Whowe Male Whowe Male Whowe ID USUAL OCCUPATION (Give kind of work done during mort of working) life, even if retired) DELITY DELITY DELITY MESTIFICATE (County & Stote, or foreign country) MESTIFICATE THORPOWERS II. BERTHFIACE (County & Stote, or foreign country) MESTIFICATE MESTIF								Where deceose	d lived, if institutio	n: Residence	befare	admissi	ion) /
b. CITY OR ROWN (It outside corporate limits, write RURAL and give nearest town) SYRES (ILLE) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) SPRINGFIELD STATE HOSPITAL d. STREET ADDRESS SPRINGFIELD STATE HOSPITAL Middle D. STATE HOSPITAL BELL BROOKS BERNARD BELL BROOKS A DATE BROOKS BERNARD BELL BROOKS BEATH LO 29 1667 S. SIX 6. COLOR OR RAGE 7. MARRID MILL MIDDRESS NO 18 BENNARD BELL BROOKS BEATH LO 29 167 S. SIX MALE White Whowe Whowe Male Whowe Male Whowe ID USUAL OCCUPATION (Give kind of work done during mort of working) life, even if retired) DELITY DELITY DELITY MESTIFICATE (County & Stote, or foreign country) MESTIFICATE THORPOWERS II. BERTHFIACE (County & Stote, or foreign country) MESTIFICATE MESTIF		CAF	ROLL		MARYLA	AND	a. SIAIE MARYL	AND	b. COUNT	REDE	RICI	K	4
A MARE OF HOSPITAL OR MINITURN (II not in hospital, give street oddress) A STREET ADDRESS A STREET ADD		b. CITY OR TOWN	(If autside corparate limits,		c. LENGTH OF STAY IN	1b			e limits, write RURA	L and give	nearest	tawn)	
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Clype or print BERNARD BISLL BROOKS Fight 10 29 19 67 10 10 10 10 10 10 10 1			First		Middle		Last		Manth		Day	Ye	ear
S. SEK 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OBJECT! 8 - 21 - 96 9. ACCE (In years lest betched) Mours Mou			BERNAR	D	BELL		BROOKS	OF DEATH	10		29	19	67
Male White WIDOMED DIVORCED O8/\$2/96 Tyres Too USBA COUPATION (CUPATION (CUPATION COURTED DIVORCED DIVORCE	S.	SEX	6. COLOR OR RACE 7. N	ARRIED	NEVER MARRIED		B. DATE OF BIRTH 8-2		AGE (In years				
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24. FUNERAL DIRECTOR Floward ADDRESS Multimore 250. REGISTRAR 25b. REGISTRAR'S SIGNATURE	230	BURIAL, CREMATI	ON, 23b. DATE THEREOF		23c. NAME OF CEMETE	RY OR (CREMATORY .	23d. LOC	ATION (City or Town	n) ((Caunty)	(5	state)
24. FUNERAL DIRECTOR + Cooper ADDRESS Metmore 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		REMOVAL (Specify	Nov. 1-19	67	Mt. Olivet	t Ce	metery	Fre	derick.	Md. 2	1.70	1	167
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		M.R.Etcl	nison & Son-	' I	Frederick, 1	Id.2			1967 P	lare	AN X	reals	Re

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely director, page 3 should be detached far use as the burial-transit permit. Then please remave carbo directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave cark shauld be filed with the State Dept. of Health priar ta burial, crematian, ar remaval, and in any event, Page 4 may be retained by the hospital ar attending physician. VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH



25	1 _	1	MARYLAND STATE DEPARTMENT OF HEALTH
	= = IM	1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH
	24 hours after death. filled in by the funeral apers. Pages 1 and 2 no 72 hours after death.	1	PLACE OF DEATH a. COUNTY B. COUNTY A. STATE D. COUNTY D.
	by the Pages 1		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
	in the P.S. Pour		UNION MILLS 34MO. WESTMINSTER
	C. sem	0	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEADON CONSV. Home 222Pema Avery YES \(\) NO P
	withir pletely arbon int, with	3	NAME OF First Middle Last 4. DATE Month Day Year OF OF DECEASED (Type or print) PLICE MARY BYERS DEATH OCT. 7 1967
	executed within and completely remove carbon any event, with	5	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS. Hours Min. Hours
		a	Oz. USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 12c. CITIZEN OF WHAT COUNTRY? CARROL COMB 10c. S. G.
	phys phys n ple val, a		3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	ding The	_	CHARLES SHIPLEY SARAH BOLLINGER
	e death certifica the attending ph it permit. Then I	(15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address SAME 214-81-1700 STERLING J. BYERS ADDRESS
	quires that the group of physician. Seen signed by the burial-transito burial, cremto burial, cr		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cenditions, If any, which gave rise to immediate cause (a), stating the DUE TO DUE TO DUE TO DUE TO
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	= = = 0		21. I certify that (I) (this hospital) attended the deceased from 7/25/67, 19, to 10/7, 19, that (I) (we) last saw the deceased alive on 8/18/19/19/27, and that death occurred at 7/35/07, from the causes and on the date stated above.
	OR AT be re- DIRECT Ige 3 s led wit		228. SIGNATURE 22b. DATE SIGNED N.D. ATTENDING MED. STAFF 10/9/67.
	O HOSPITAL OR ATTEND Page 4 may be retained O FUNERAL DIRECTOR. 4 director, page 3 should should be filed with the	1	22c. Physician's NAME (Type) 22d. ADDRESS 150.W. Macn St. Westminster Md.
	TO HOSP Page 4 TO FUNE directo) 2	38. BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) . (State) DERIVED CT 11.67 REMOVAL (Specify) OCT 11.67 REPORT RURAL NESTMINSTER
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Lems #8 & 9 & 10a Film #6393 10/16/67 ph

CERTIFICATE OF DEATH 13698 24 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY Balto. City o. COUNTY a STATE Carroll MARYLAND Marvland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 1b Svkesville 24vrs.Lmos. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ⊇. within 72 05 SELFRIDGE Springfield State Hospital NAME OF remove carbon DATE DECEASED event, (Type or print) DEATH October Henry Chronister OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed comple IF UNDER 1 YEAR 9. AGE (In years 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED Months birthdoy) and in any Male WIDOWED DIVORCED 8-11-83 White pup 10b. KIND OF BUSINESS OR 100. USUAL OCCUPATION (Give kind of work done during most of working life even if refired) Peign 10b. KIND OF BUSINESS OR INDUSTRY RAILroad Night Watchman Handle Penn. Railroad 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) please COUNTRY? U.S.A Pennsylvania

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar removal CATHERINE SMALL Samuel Chronister 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service Springfield State Hospital Records. crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I, DEATH WAS CAUSED BY Bronchopneumonia IMMEDIATE CAUSE (o). DUE TO burial. Arteriosclerotic cardiovascular disease Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying cause as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) this certificate has 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) 2]. I certify that (I) (this haspital) attended the deceased from 6-30-13 . 19 ____, to__10-9-67___, 19____, that (I) (we) last and that death accurred at 3:00cM, fram causes and an the date stated above. saw the deceased alive an 10-9-67 TO FUNERAL DIRECTOR: 220. STGNATURE 22b. DATE SIGNED 10-9-67 DIRECTOR PHYS. M.D. Ach 22d. ADDRESS 22c. PHYSICIAN'S pe Glecrite Sagisi, M.D. Springfield Hosp, Sykesville, Md. director, 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify) ATHEORAL

ADDRESS

300

MARYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE

ON A FARM?

Year

IF UNDER 24 HRS

Hours

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

NO

(Stote)

(Stote)

2Sb. REGISTRAR'S SIGNATURE

2So. REC'D BY REGISTRAR

YES T

Years

NO Ta

10 HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending VR A15 (4)

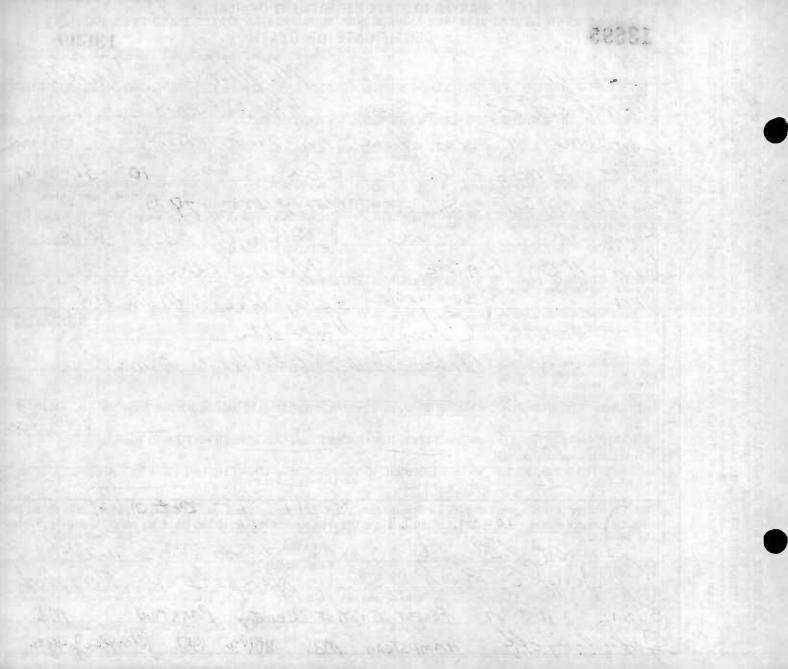
24. FUNERAL DIRECTOR

J.G. CONNELL

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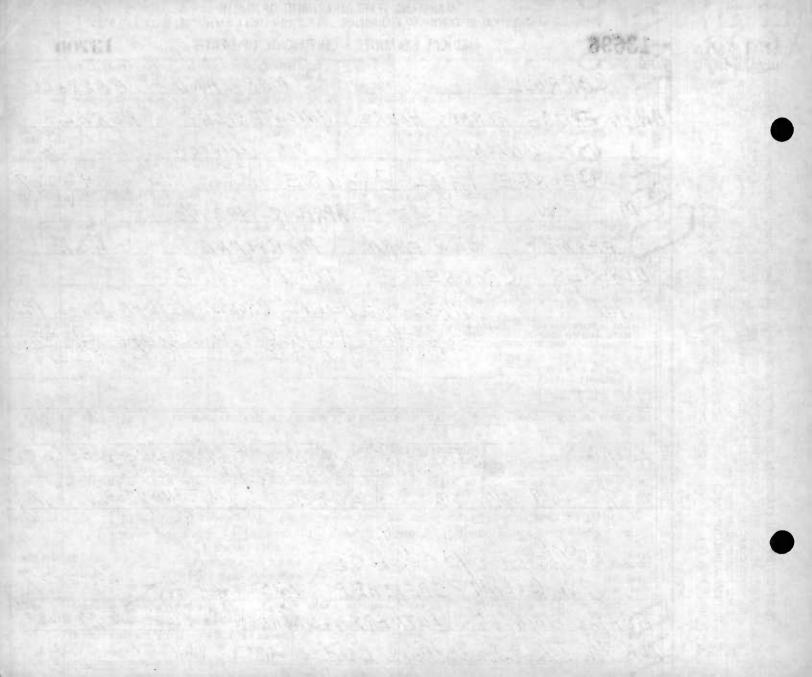
RETURN

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH uneral and 2 death. death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution-Residence before admission) a. COUNTY b. COUNTY by the Pages MARYLAND pers. Pages 72 hours arte b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN of outside corporate limits, write RURAL and give nearest town) hours 드 e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Filled within . NO YES completely ve carbon p executed within NAME OF Last DATE Month Day Year Middle DECEASED. event, (Type or print) DEATH 19 AGE (In years | IF UNDER 1 YEAR | Months | Days 5. SEX 6. COLOR OR RACE | DATE OF BIRTH IF UNDER 24 HRS 8. remove n any eve 7. MARRIED NEVER MARRIED Hours WIDOWED DIVORCED v/s.9 nding physician a .. Then please re removal, and in E 10a. USUAL OCCUPATION (Give kind of work done during most of working life, eyen if retired) INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Louse WI certificate FATHER'S NAME MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address been signed by the attenthe burial-transit permit. death (Yes, no, or unkown) (If yes give war or dates of service) 716-07-2613 INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per ine for (a), (b), and (c), PHYSICIAN: The law requires that the 18. ONSET AND DEATH PART I. DEATH WAS CAUSED BY the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the as th underlying cause last. this certificate has (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? for use Health p NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING [7] detached for te Dept. of h OR CONTRIBUTING CAUSE OF DEATH TO FUNERAL DIRECTOR: After this ce director, page 3 should be detache should be filed with the State Dept. MEDICAL 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour While Not While be retained by 19 at work at work 21. Teartify that (I) (this hospital) attended the deceased from_ MARCLI 19 (1), and that death occurred at 4 M. from the causes and on the date stated above. deceased alive on_ 10-27. saw the 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR M.D. PHYS. Page 4 may PHYSICIAN'S 22d. ADDRESS NAME (Type 23d. LOCATION (City, town or county NAME OF CEMETERY OR CREMATORY BURYAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) BURIAL KTOK emetery PARI 25b. REGISTRAR'S SIGNATUR 24. EUNERAL DIRECTOR 196 VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13696 MEDICAL EXAMINER'S CERTIFICATE OF FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a COLINTY Page 0 MARYLAND and 3 c. LENGTH OF STAY IN 1b CITY OR TOWN (IF autside corporate limits, write RURAL and give nearest tawn) PM3 after (If not in haspital, give street address) IS RESIDENCE ON A FARM? form haurs UNION IX NO Pages ate after death. 3. NAME OF 4 DATE First Month Dov Year DECEASED OF DEATH with the (Type or print) 9. AGE (In years 6. COLOR OR RACE 7. MARRIED last birthday) Months Doys Haurs 9 WIDOWED DIVORCED Office of and 2 event 1Dg, USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of warking life, even if retired) Examiner's 13. FATHER'S 14. MOTHER'S MAIDEN NAME be executed within = BOND and 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give war or dates of service removal, CROUSE 18. CAUSE OF DEATH (Enter only one couse per line for (a), PART I. DEATH WAS CAUSED BY JD IMMEDIATE CAUSE (a) ward certificate should crematian, DUE TO Canditians, if any, which gave rise to immediate couse (a). DUE TO 0 stating the underlying couse farwarded SD last. burial, WAS AUTOPSY PERFORMED? PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES [NO to 2Do. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. HOW INJURY OCCURRED. (Entershoture of injury in Po priar 2Dc. TIME OF INJURY Month, Doy, Year 2De PLACE OF INJURY (Home form Not While factory, street, affice bldg., etc.) FUNERAL DIRECTOR: Page at wark designated 21. I certify that I taok charge of the remains described above, held an Autapsy Inspection X Inquiry and in my apinian death resulted fram: Natural causes IX Accident X Suicide Undetermined manner Homicide may be retained please CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY 9 DEPLITY MEDICAL EXAMINER **EXAMINER'S** ealth NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF 0 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15ME 6M 1/66 limites 1967

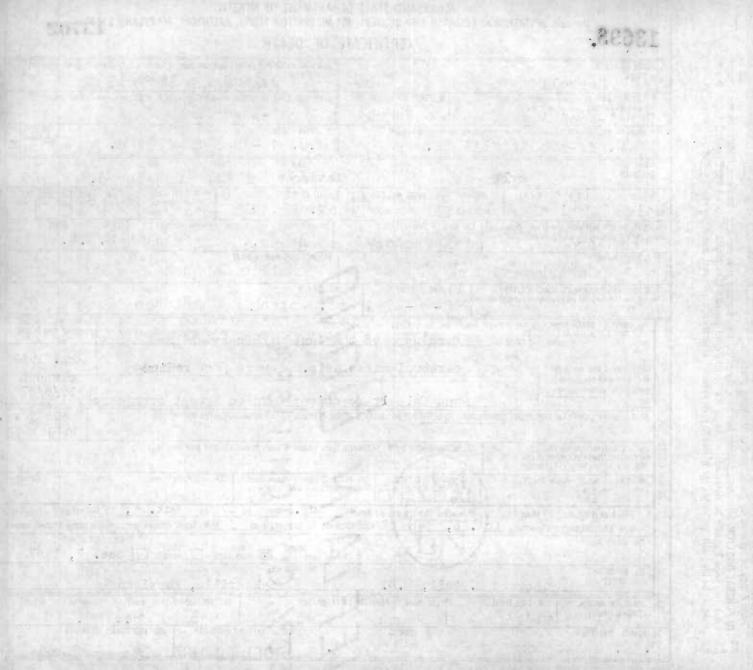
MARYLAND STATE DEPARTMENT OF HEALTH



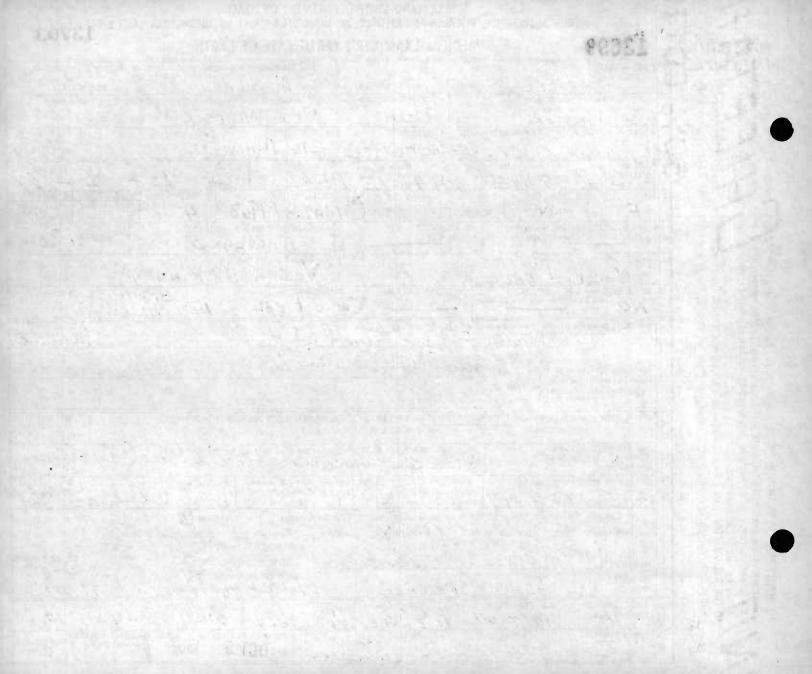
FOR STATE	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH OFFT.	1. PLACE OF DEATH O. COUNTY Carroll 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) O. STATE Maryland Beltimore City
\$ 8 d	Carroll Maryland Maryland Beltimore City
delay and 3 M3. Poor	Write RUKAL and give nearest fown)
> " A 3	Rural - Sykesville 1 mo. 22 da. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e. IS. RESIDENCE
hours offer death. If an Item 18. Give Pages 1-3 Office along with form I and 2 with the State Depart death.	Springfield State Hospital 3835 Sequoia Avenue YES NO K
Pag Pag Sto	3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED OF
r d g w	(Type or print) BERNARD GILBERT DANGERFIELD, Jr. DEATH /0 - 24 1967
ofter death. 8. Give Page along with the Starth.	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Lost birthdoy) Months Doys Hours Min.
rrs (e o ath	Male Negro WIDOWED 3-12-444 23 yrs.
hours Item 18 Office Iand 2 v	10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
24 hours in Item 18 r's Office c	Clerk Unk. Baltimore, Maryland USA
within 24 pencil in cominer's le pages hours affe	13. FATHER'S NAME
be executed within "pending" in pencil itef Medicol Exomine onsit permit. File pagent within 72 hours	Bernard G. Dangerfield, Sr. Carrie Jones
ed in In In It. Fit	15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SOCIAL SECURITY ND. 17. INFDRMANT Address
xecuted nding" ir Medicol I permit. 1	(Yes, no, or unknown) (If yes give wor or dotes of service) Yes 1966 219-40-5206 Records, Springfield State Hospital
e should the word to the Ch i burial-tro	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gove rise to immediate cause (a), stoting the underlying couse lost. (c) PENDING STAND DEATH PENDING STAND DEATH DUE TO (c)
ACAL EXAMINER: This certificat be execute the certificate, writing ctor. Page 4 should be forworded for your files. ECTOR: Page 3 should be used as a buriol, cremation, ar removal, and	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
INER: This to certificate, should be for files.	PERFORMED? YES NO CAUSE DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) PRIMARY Or CONTRIBUTING CAUSE DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
EXAMINER: cute the certi oge 4 should r your files. :Page 3 shou cremation, a	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 Ot work of work for ot work of
NEXA xecute Poge for you OR: Page ol, crem	21. I certify that I took charge of the remains described above, held on Autopsy X, Inspection , Inquiry , and in my opinion
se exestor. Pertor. Pe	deoth resulted from: Maturol couses (A., Accident], Suicide], Homicide] Undetermined monner
	ACTUAL SIGNATURE CHIEF MEDICAL EXAMINER (1) 22. DATE SIGNED
ry, pleaseral directain Be retain RAL DIR	DEDITY MEDICAL EVALUATION AT 10-75-61
DEPUTY cessory, e funeral moy be n FUNERAL	EXAMINER'S NAME (Type) W. Glenn Speecher, M. D. 135 Habour St. Westween St. Westwee
to DEPUT necessory the funero 5 may be 0 FUNERA	230 BURIAL CREMATION 23b DATE THEREOF 230 NAME OF CEMETERY OR CREMATORY 23d DOCATION (City or Town) (County) (Store)
ひっきゃっちゃん	REMOVAL (Specify)
IM	24 FUNERAL DIRECTOR 250. REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME (5)	MORTONE Dyett Fit 1701 LAURENS St. DATE OCT 27 1967 Johnson Judge
6M 1/67	[WRYON & Dyett tit 110 LAURENS St DATE OCI 21 1961 Charles Judge

TISKE T Combinations of the second second second nament stoppe of the state of t The time time is the start contemporary, the first of the start of the martin de e dans de la stati The manufactured of the control of t Tatalines to be a line of the contract of the

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death). PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland a. COUNTY Carroll MARYLAND c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Years Rural-Woodbine Rural-Woodbine d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? R.D. 1 - Hoods Mill Rd. 1 - Hoods Mill Rd. R.D. YES NO IX NAME OF First Middle 4. DATE Month Last Day DECEASED Worley Davidson October DEATH (Type or print) S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR LIFTINDER 24 HRS 7. MARRIED NEVER MARRIED) last birthdoy) Male White lov. 23, 1923 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) Box Factory COUNTRY? Wise Co. Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Hobert Davidson Sallie Johnson 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) ((If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address 230=28-979 Same As #2 Mrs. Josephine Davidson burial, crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Carcinoma of the lung with cervical and IMMEDIATE CAUSE (a) attending physician. DUE TO Aug. 1967 Conditions, if ony, which gave cerebral metastasis. Severe post radium rise to immediate couse (o), through DUF TO stating the underlying cause and Colbott reaction; Cardiac arrest from cerebral pres O FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar to 19. WAS AUTOPSY Te PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES T NO O HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the haspital ar 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a.m. Not While of work of work Oct. 6, 19 6/, that (1) (we) last Aug. , 19 6/, ta___ 21. I certify that (I) (this haspital) attended the deceased fram____ saw the deceased alive an Oct. 6. 19 67, and that death accurred at 5 PM, from causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. X Oct. 7, 1967 DIRECTOR M.D 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23h DATE THEREOF (County) REMOVAL (Specify) Sharon Baptist Howard Co., 25o. REC'D BY REGISTRAR 25h REGISTRÁR'S SIGNATURE 24. FUNERAL DIRECTOR M. Waltz Box 241 Sykesville, Md. 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120J MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13699 FOR STATE DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY of 0 P.M.3. Page deoth. MARYLAND ARROLL delay and 3 partment CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN outside corparate limits, write RURAL and give nearest tawn) ofter ESTMINSTER OF HOSPITAL OR INSTITUTION (If nat in haspital, give street e IS RESIDENC De orm ON A FARM hours YES NO 24 hours ofter death. NAME OF Last 4. DATE Month Doy Year 72 DECEASED (Type or print) DEATH within SEX 9. AGE (In years COLOR OR 7. MARRIED NEVER MARRIED DATE OF BIRTH W (get/birthday) Item 18. Office al Manths Haurs WIDOWED DIVORCED event 2 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during mast of working life, even if retired) INDUSTRY COUNTRY? AN Ony the Chief Medical Examiner's poges 13. FATHER'S NAME MOTHER'S MAIDEN NAMI pencil be executed within 2 puo 15. WAS DECEASED EVER IN U.S. ARMED FORCES? **INFORMAN** (Yes, no, or unknown) (If yes give war ar dates af service permit. removol, pending" CAUSE OF DEATH (Enter anly one couse per line for (a), INTERVAL BETWI burial-transit PART I. DEATH WAS CAUSED BY PINSET AND DO 0 IMMEDIATE CAUSE (a) This certificate should writing the ward cons & Chroxcons crematian, DUE TO Canditians, if any, which gave (6 should be forwarded to rise to immediate couse (a). DUE TO 0 stating the underlying cause GS last. burial, used WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION the certificote. 0 pe 20g. EXTERNAL CAUSE WAS PRIMARY TO GET CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Ruth I or Porty II its designated ogent, prior 3 should EXAMINER: files. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE_OF INJURY (Home, farm, County) Nat While FUNERAL DIRECTOR: Poge pleose execute at work certify that I taok charge of the remains described above, held on Autopsy for Inspection ond in my opinion director. deoth resulted from: Notural causes Suicide Accident IX Homicide Undetermined manner may be retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE the funerol TO DEPUTY 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health NAME (Type) BURIAL, CREMATION LOCATION (City or Town 2 BY REGISTRAR 24. FUNERAL DIRECTOR 2Sb. VR A15ME 6M 1/66



250 REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

VR A15 (4) 25M 1/67 24. FUNERAL DIRECTOR

84. THERE THE TRAIN OF THE PARTY OF THE P TOSE C CTAN IN THE SECT.

TON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence a. COUNTY ARROLL MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 (If outside corporate limits, write RURAL and give neerest town) write RURAL and give nearest town DLEBURG d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address e. IS RESIDENCE ON A FARM? YES NO S NAME OF Middle 4. DATE Month Day DECEASED OF DEATH (Typa or print) 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Hours 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Address EVER IN U.S. ARMED FORCES? ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? NO CERTIFIC 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) 2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED lactory, street, office bldg., etc. While Not While D.m 6 19....., that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from......19......., and that death occurred at / 15.K, from the causes and on the date stated above. saw the deceased alive on. ATTENDING 22a. SIGNATURE 22b. DATE STAFF SIGNED DIRECTOR PHYS. FUNERAL 22d. ADDRESS 22c. PHYSICIANS 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 0 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATUR VR A1S

CHREENS TO THE BRIDGE

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decaased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll MARYLAND Carroll b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Westminster Rural Westminster Route 7 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Carroll 3. NAME OF Mayberr General DATE Month Day Yeer DECEASED OF 196 (Type or print) DEATH (none) Drabic Michael 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? (County & State, or foreign country) done during most of working life, even if retired) Northampton, Pa. USA own farm farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Drabic Ti.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Tillie Seedor Admoute 7 (Yes, no, or unkown) | (If yes give wer or dates of service) Westminster; Md. -0752 Doretta M. Drabic 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: PNGESTIVE WEEKS IMMEDIATE CAUSE (a) DUE TO ARTERIOSCIEROTIC HEART DISKASK Conditions, if eny, which geve rise to immediate cause DUE TO (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO T 200. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH 2De. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED ! 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While Hour a.m. at work at work p.m SIGNATURE SIGNED ATTENDING PHYS. DIRECTOR 22d. ADDRESS PHYSICIAN'S NAME (Type) Westminster, Md. Fiocco, Jr. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (Stete) g di REMOVAL (Specify) 0 Meadow Branch Cemetery Westminster Buria] VR A15 (4) 15M 7/61

RYLAND STATE DEPARTMENT OF HEALTH

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PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Carroll Maryland Howard MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside carporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) 15 days Fulton - Rural Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital Rt. 215 YES NO X 3. NAME OF Middle First Last 4. DATE Month Day Year DECEASED CHARLES DAVID FORCE OCTOBER 19 (Type or print) DEATH IF UNDER 1 YEAR IF LINDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years NEVER MARRIED last birthday) Manths Days Hours DIVORCED TE 1-23-06 White WIDOWED Male 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
Carpenter COUNTRY? **INDUSTRY** Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Force Catharine Gitchell 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, ar unknown) (If yes give war ar dates of service) 577-18-5730 Records, Springfield State Hospital INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY: Days IMMEDIATE CAUSE (a) Bronchopneumonia, due to probable aspiration Conditions, if ony, which gove Right heart failure Weeks rise ta immediate cause (a), DUE TO stoting the underlying couse (c) Emphysema Years 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES X NO 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) Haur o.m. factory, street, office blda., etc.) at wark at wark 21. I certify that (1) (this hospital) attended the deceased fram. saw the deceased alive an 10-12-67 and that death accurred at 19 M, fram causes and an the date stated above. 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. DIRECTOR Springfield State 22c. PHYSICIAN'S 22d. ADDRESS Hespital Sykeswille, Maryland NAME (Type) Paul G. Ensor, M. 23b. DATE THEREOF NAME OF CEMETERY OR CREMAJORY 23d. LOCATION (City or Town) 23a. BURIAL CREMATION. (County) (State) 2So. REOD BY REGISTRAR 2Sb. REGISTRAK'S SIGNATURE **FUNERAL DIRECTOR**

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death within dar banepa event, and attending physician sermit. Then please or remayal, crematian, burial-transit signed Page 4 may be retained by the haspital or attending be detached far use as the State Dept. af Health prior ta certificate has directar, page 3 shauld shauld be filed with the TO FUNERAL DIRECTOR:

> VR A15 (4) 25M 1/67

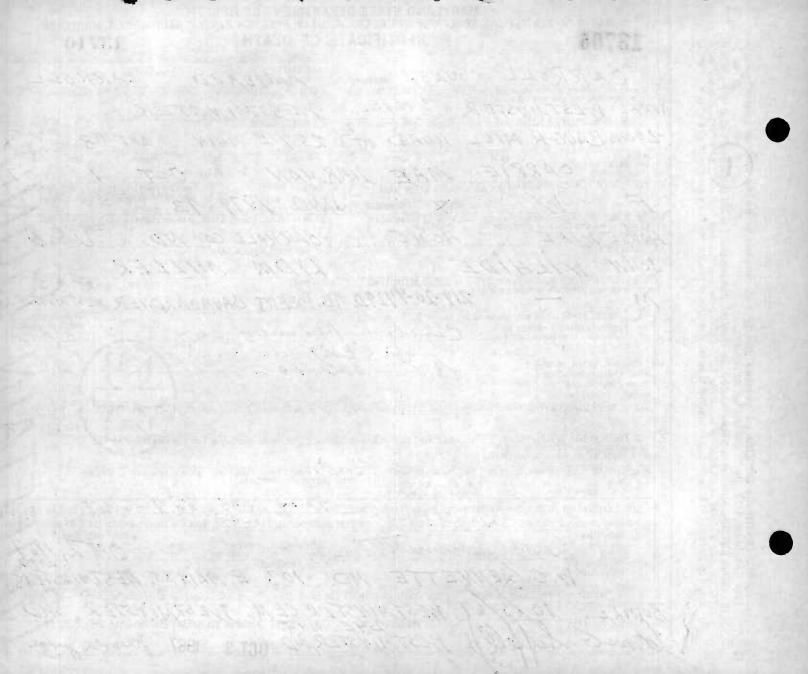
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13208 CERTIFICATE OF DEATH 13704 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. County Carroll o. COUNTY o. STATE Carroll Maryland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b The law requires that the death certificate be executed within 24 hours Westminster vears IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS on poper 147 Liberty St. Liberty St. YES NO X 3. NAME OF 4. DATE Middle Last First Month Doy Year DECEASED corbé HOWARD EART. FROUNFELTER October (Type or print) DEATH 9. AGE (In years last birthday) S. SEX DATE OF BIRTH IF UNDER 1 YEAR 6. COLOR OR RACE X NEVER MARRIED 7. MARRIED Days male white Sept. 1894 WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT Water during most of working life even if retired COUNTRY? Carroll County. Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol, cremation, or removol. William Frounfelter Catherine Myers 17. INFORMANT Liberty StidressWestminster. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 212-14-7761 Mrs. Frances B. Frounfelter. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: buriol-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) by the hospital or attending physicion. DUE TO Conditions, if ony, which gave rise to immediate couse (a), DUE TO stating the underlying couse last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use with the State Dept. of Health NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, farm. (City or town) (State) 20d. INJURY OCCURRED (County) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, affice bldg., etc.) Not While at work **DIRECTOR:** After 21. I certify that (1) (this hospital) ottended the deceased fram from 4 23, 1967, that (I) (we) last 1967, and that death accurred at 456 M, fram causes and an the date stated above saw the deceased alive an alors 22b. DATE SIGNED 220 SIGNATURE MED. DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S AME (Type) Glenn Speicher. M.D. Main St. Westminster director, a Maryland 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) BAGAN PROIN Oct.1967 Winters Cemetery Carroll County 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Wew Windsor.

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MARYLAND STATE DEPARTMENT OF HEALTH

/	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
Ė	E04.	13706 CERTIFICATE OF DEATH 13710	
er deat	a funer I and ter deat	1. PLACE OF DEATH a. COUNTY ARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admiss a. STATE ARROLL MARYLAND b. COUNTY B. COUNTY ARRIVAD	ion)
hours aft	in by the Pages iours aft	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	NN)
24 hg	i completely filled in by to ove carbon papers. Page y event, within 72 hours an	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LUCABAUGH MILL ROAD RT3 257 L. MAIN APT #8 YES NO	1?
WITH	prefely carbon nt, with	3. NAME OF DECEASED (Type or print) CARRIE MAKE HARMAN. DAY Year DEATH OCT / 196	フ
executed	and con remove	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED AN 23/874 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 Hours M) WIDOWED VIOLENCE OF BIRTH WIDOWED VIOLENCE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 Hours M) WIDOWED VIOLENCE OF BIRTH WIDOWED VIOLENCE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HOURS M) WIDOWED VIOLENCE OF BIRTH ON THE PROPERTY OF THE PR	IRS. In.
	sician a lease re and in	102. USUAL OCCUPATION (GIVE kind of work done during most of working life, even If retired) 104. USUAL OCCUPATION (GIVE kind of work done lindustry) 105. KIND OF BUSINESS OR lindustry 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. COUNTRY?	
rtificat	ing phy Then p moval,	13. FATHER'S NAME JOHN WILHIDE 14. MOTHER'S MAIDEN NAME LYDIA MILLER	
eath ce	attendi ermit. in, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address RT & 3 (Yes, no, or unknown) (If yes give war or dates of service) 219-20-47290. MRS. ROBERT BAUMAA RONER WESTHINSTER	1
PHYSICIAN: The law requires that the death certificate be	nospital or attending physician, certificate has been signed by the attending physician ched for use as the burial-transit permit. Then please ript, of Health prior to burial, cremation, or removal, and in	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the DUE TO underlying cause last. (c)	TH -
The law	or att	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOP PERFORMED YES NO 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
SICIAN	the nospital this certific detached for the Dept. of He		
	ed by the no After this d be detach e State Dept	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. While at work of at work a)
ATTENDI	be retained IIRECTOR: Af ge 3 should I ge with the S	21. I certify that (I) (this hospital) attended the deceased from	
PITAL	RAL D	22c. PHYSICIAN'S NAME (Type) W. C. (AKNNETTE MD. 103 E. MAIN ST. MESTMINSTERS	107
TO HO	Page 4 n TO FUNER, director, should be	23a. BURIAL, CREMATION, 23b. DATE PHEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 10/3/67 WESTMINSTER CEMETERY OF CREMATORY 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR 1/1/20 ADDRESS 75 4 F. MAIN ST25a. REC'D BY REGISTRAR'S SIGNATURE	-4-
	AIS (4) M 1/65	Lames G. Suffell & MESTMINSTER, MEDATOGT 3 1967 yourses Junge	



. 1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
+		13707 CERTIFICATE OF DEATH
death death	1.	PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
# 21 p		Carroll Maryland Carroll
> 50 00		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
3 C 0		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 9. IS RESIDENCE DN A FARM?
ithig 24 ho rely filled i bon papers. within 72 h	Z	ong View Nursing Home R+3 YES NO
	3.	NAME F DECEMBED Charles Middle Last First Month Day Year 1967
comple we sa	5.	SEX 6. COLDR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS.
xect and emo any	1	Male While WIDDWED DIVORCED 1/22/1880 86 yrs.
	dur	. USUAL OCCUPATION (Give kind of workdone Ing most of working life, even if retired) 10b. KIND DF BUSINESS OR II. BIRTHLAGE (County & State, or foreign country) 11. BIRTHLAGE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
cate physi	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ertifica ding ph Then remova		Leander Hull MATY huckAbAugh
th the mit.	(Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT of the little Address (If yes give war or dates of service)
nt the death can an by the atten ransit permit. cremation, or		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
that the sician. gned by al-transi		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corehral Thrombour 3Months
ries that the physician. I signed by burial-transi burial, crem		Conditions, If any, which DUE TD arternordenster Candir-Varally 5 ws
ding pl ding been seen seen seen seen seen seen seen		gave rise to Immediate cause (a), stating the DUE TO
aw re tendi las b as th prior	N	underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
I: The la al or at fificate h for use Health	CATIO	PARTITION FOR SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PARTITION OF THE PERFORMED? YES NO FILE.
	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN: the hospital this certifi detached fo ce Dept. of H		(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
oing phy d by the After thi d be det s State Di	MEDICAL	Hour a.m. p.m. While at work at work at work
ATTENDING retained by CCTOR: After Should be with the Star		21. I certify that (1) (this hospital) attended the deceased from Sent, 1944, to Oct 24, 1967, that (1) (we) last
OR ATTEND y be retained OIRECTOR: J age 3 should lied with the		saw the deceased alive on Oct 24 1967, and that death occurred at 4.75 M, from the causes and on the date stated above.
AL OR DAY be page filed		M.D. ATTENDING DIRECTOR DIRECTOR DIVECTOR DIVECT
TO HOSPITAL OR ATTENDIN Page 4 may be retained TO FUNERAL DIRECTOR: Af director, page 3 should I should be filed with the S		22c. PHYSICIAN'S NAME (Type) W. H FO Ard U.P 22d. ADDRESS NAME (Type) W. H FO Ard U.P MANCHESTER AND 21102
O HOSPITA Page 4 m O FUNERAL director, p	232	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
E 5	24	FUNERAL DIRECTOR ADDRESS 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE
VR A15 (4)	3	J. E. muero A. Westminster and DATE OCT 3 1 1967 felianles Judge



hin 24 hours after in by the funeral death. Page (Carolinate Description of Attention of Harding physician).

TO FUNERAL CECTOR: After this certificate has been signed by the attending physician and complete director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Page be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours

VR A15 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 137792

								A U TO CAUPA	~
1. PLACE OF DEAT	гн			2. USUAL RESIDEN	ICE (Where d			dence before a	admission)
2. COOM1	Carroll		MARYLAND	a, STATE	Md.	b. COU	Ca:	rroll	
	(if outside corporate limind give nearest town)	ts,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside con	porate limits, writ	e RURAL and g	ive neerest tow	vn)
Westmin	ster			Westminst	ter			0	6 /
d. NAME OF HOS	PITAL OR INSTITUTION (if not in ho	spital, give street address)	d. STREET ADDRESS					ESIDENCE A FARM?
Carro	11 Co. Hene	ral H	ospital	Rexis Aver	nue Per	rv Hall	21128	YES [NO
3. NAME OF DECEASED	First		Middle	Last	4. DATE	Mont		Day Yee	r
(Type or print)	John		W.	Jasper	DEATH	70		26 196	- 1
5. SEX	6. COLOR OR RACE	7. MARRI	ED NEVER MARRIED 8	. DATE OF BIRTH	9	9. AGE (In years last birthday)	Months De		Min.
Male	Cac	WIDOW	ED DIVORCED	8- 15-1905		62 yrs.	Months De	/s nous	Min.
IOa. USUAL OCCUPA	TION (Give kind of work working life, even if retire	10ь. І	OND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (Cour	nty & State, o	r foreign country)	12. CITIZE	N OF WHAT	COUNTRY
44	perator		Lack & Decker	Balto. Md.	•		U.	S.A.	
13. FATHER'S NAME		200		14. MOTHER'S MAIDEN	NAME				
	Frederick J.	asper			Mar	garet M	ulhause	n	
15. WAS DECEASED E	VER IN U.S. ARMED FOR	CES? 16	SOCIAL SECURITY NO. 17.	NFORMANT	William.	Address			
(Yes, no, or unkown)	(If yes give wer or dates of s		18-03-0684 M	s Barbara Ja	ener l	derie Ro	ad Ferr	r Hall	Md.
	DEATH Enter only one			S Dar Dar G O	apher .	CALS IO	au cii	INTERVAL BET	
	TH WAS CAUSED BY, IMMEDIATE CAUSE (a)		10. (0), (0), 0 (0),					ONSET AND	
4201	DUE TO				•			- 1	
Conditions, if ea		(Coronary	Thrombo	ara.		7 11	Bhon	-
gave rise to imme	diate cause		8						
(a), stating the cause last.	underlying DUE TO								
PART II. OTH		TIONS CO	NTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMI	INAL DISEASE	CONDITION GIV	EN IN PART 1	19. WAS A	
ATT ATT		100						1	NO T
20a ACCIDENT	WAS UNDERLYING T	20b. DF	SCRIBE HOW INJURY OCCURED	. (Enter neture of Injury in	Pert I or Pert	Il of item 18.)		1	
OR CONTRIBUTIN	G CAUSE OF DEATH								
20c. TIME OF IN.		ar 20d. Whil		CE OF INJURY (Home, far ory, street, office bldg., etc		ty or town)	(County)	(Stele)
Nour a.m.			ork at work						
		al) atter	nded the deceased from.	10/26	1947. 10	10/24	19 5	that (1) ((we) last
			19.67, and that	. 49	45			date state	d above
22e. SIGNATURE		lars	her M		MED. DIRECTOR [STAFF PHYS.	10/	26/67	SIGNED
22c. PHYSICIAN'			ARSHEY, M.D.	22d ADDRESS Quelos	it.	Wester	- inte	-d	
23a. BURIAL, CREMA REMOVAL (Specif	TION, 23b. DATE THE	REOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LO	CATION (City, to	wn or county)	(\$	itate)
Burial	10-30-1	967	St/ Micheal'	c Cemeters	Bal	timore C	0.	Mo	d
24 FUNERAL DIRECTO	OR'S SIGNATURE	101	ADDRESS	31, 25a. RE		STRAR 25b. RE	GISTRAR'S SIG		
.35		1,50	7-461 BDen Br		CT 30	1967	Milarl	as Judg	A Promise
Tennalmi	MILLETT	enn	1-121 19 1124, 17	LLV DAIE	11.1 .5 11	1001	7	-/1_(/	-

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	DIVISION OF STATISTICAL RESEARCH AND RECO	RDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR	RYLAND
77	Item #16 Film #0394	ATE OF DEATH	13714
9	1. PLACE OF DEATH •. COUNTY Carroll MARYLANI	a. STATE b. COUNTY Carroll	nce before admission)
	b. City OR TOWN (if outside corporate limits, write RURAL and give nearest town)	b c. CITY OR TOWN (If outside corporata limits, write RURAL and give	naerest town)
	Rural, Sykesville 2 Weeks	Rutal, Taneytown, Md.	06-1
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)	d. STREET ADDRESS Mailing Address	e. 15 RESIDENCE ON A FARM?
	Pullens Nursing Home	Littlestown, Pa. R. B. 1	YES NO
	3. NAME OF DECEASED (Type or print) Charles 4.	Keefer 1. DATE OF BOY 31	19 6 7
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR last birthday) Months Days	IF UNDER 24 HRS.
	Male White WIDOWED DIVORCED	5/11/1898 69 yrs.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, evan if retired) Farming Farms	STRY II. BIRTHPLACE (County & Stete, or foreign country) 12. CITIZEN C Carroll County, Md. U.S.A	OF WHAT COUNTRY?
1	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	John H. Keefer	Susanna Hahn	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 (Yes, no, or unknown) (Ifyesgivewerordates of service)	. INFORMANT Address	190-19-
	No 215-32-5888 1	drs. Henry Eckard, Littlestown, Pa.	R. D. 1
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]		TERVAL BETWEEN NSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	red 69	3 mes.
	Conditions, if any, which (b) Car Cino	ma N Bladdes 1	ers.
	gava rise to immadiate cousa (a), stating the underlying causa last.	7	1
1	(c)	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
2 3		land al se	YES NO THE
014144	200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU OR CONTRIBUTING CAUSE OF DEATH OUT (IF EITHER, NOTIFY MEDICAL EXAMINER)	RED. (Enter neture of injury in Pert I or Part II of item 18.)	
		PLACE OF INJURY (Home, farm, 20f. (City or town) (County) fectory, street, office bidg., etc.)	(State)
	21. I certify that (I) (this hospital) attended the deceased fro	m OCF 20 196/10 00+31 196/	that (I) (we) last
	saw the deceased alive on OCF 20 19.6. 7, and the	nat death occurred al. M, from the causes and on the dat	
	22e. SIGNATURE	ATTENDING MED. STAFF	22b. DATE SIGNED
1	Says Vku man	M.D. PHYS. DIRECTOR PHYS.	167 SIGNED
	22c. PHYSICIAN'S Sani Okutman	Sylveraille, Hd	
1	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETE REMOVAL (Specify)		(State)
2	Burial 11/3/67 St. Marys	Cemetery Silver Run, Carroll C	County, Md
Y	24 FUNERAL DIRECTOR'S SUSNATURE ADDRESS	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNA	TURE YMAR
	X 1 Place of A -D / To Littlesto	wn, Pao DATE NUV 3	0 0

MARYLAND STATE DEPARTMENT OF HEALTH

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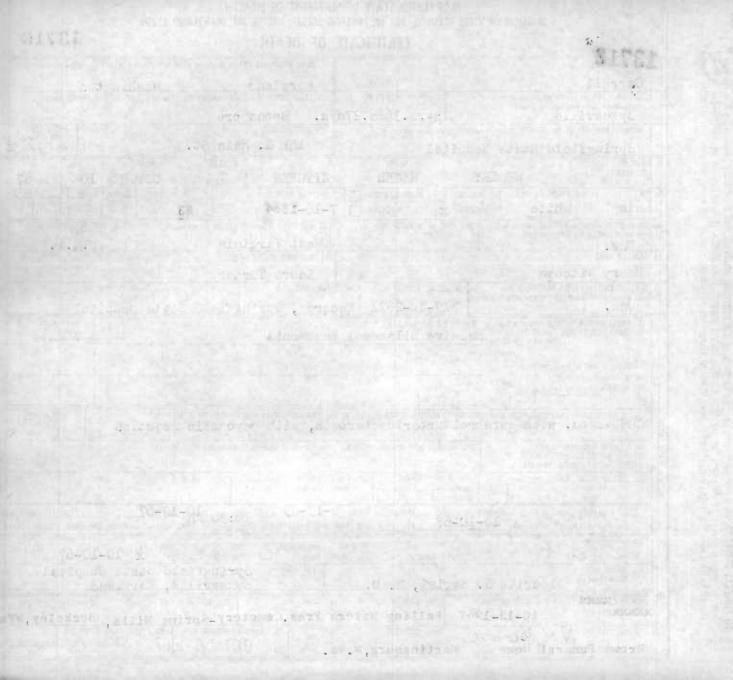
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. o. COUNTY Carroll b. COUNTY Carroll MARYLAND physician and campletery filled in by the en please remove carbon papers. Pages oval, and in any event, within 72 hours aft b. CITY OR TOWN (If autside carparote limits, write RURAL and give pearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside corparate limits, write RURAL and give nearest town) Sykesville life Sykesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If ngt in hospital, give street address) Oaklahoma Road 00 Oaklahoma Road YES NO F 3. NAME OF Middle 4. DATE Lost Month Day Year DECEASED (Type or print) 19 67 October Alvina King DEATH S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** birthday) Hours 10-28-1906 WIDOWED DIVORCED Female Negro 11. BIRTHPLACE (County & State, or foreign country) 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most af warking life, even if retired) COUNTRY? INDUSTRY Maryland Home Housewile 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Bertha Rheubottom Clarence Thomas 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, or unknown) (If yes give wor or dates of service) 218-32-98 Mr. Harry King Syke sville, Md. 18. CAUSE OF DEATH (Enter only one cause per line far (o), (b), and (t).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Cardiac failure, bronchial pneumonia, IMMEDIATE CAUSE (a) _ DUE TO 1960 Severe arthritis . Convulsive seizures through Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause 10/1/67 TO FUNERAL DIRECTOR: After this certificate has been the Anemia PHYSICIAN: The law 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES 🗍 NO X for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While ot work to Oct. 1, 1967, that (1) (we) lost 21. I certify that (I) (this hospital) attended the deceosed from____ 1960 Page 4 may be retained sow the deceased alive on Oct. 1, 1967, and that death occurred at 9:00 PM, from causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE Sz Oct. 2, 1967 DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S director, pa Howard E. Hall, M.D. NAME (Type) Sykesville, Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 230 BURIAL, CREMATION, (State) REMOVAL (Specify) Rock Cemetery SURPSVIlle 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Milaries 1967 DATE OCT

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

40719			CENTIFIC	ATE OF DEATH		19/10
o. COUNTY Carrol			MARYLA	o. STATE	b. col	ution: Residence before admission) UNIY Shington
b. CITY OR TOWN	(If autside corporate limits		LENGTH OF STAY IN 1	L C. CITY OR TOWN (If or	tside carporate limits, write R	
	ITAL OR INSTITUTION (If no			d. STREET ADDRESS	Main St.	e. IS RESIDENCE ON A FARM? YES NO IX
3. NAME OF DECEASED (Type or print)	Fir	-	Middle KIMEL	KI TCHEN	4. DATE MOI OF DEATH OC	TOBER 10 19 67
s. sex Male	6. COLOR OR RACE White	7. MARRIED WIDOWED K	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 7-16-1884	9. AGE (In years last birthdoy) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
during mast af workin Unk	ON (Give kind af work done g life, even if retired)	10b. KIND (INDUST	OF BUSINESS OR TRY	West Virg		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry	itchen	SPEEDS.	and the same	14. MOTHER'S MAIDEN Laura Tu		
15. WAS DECEASED EV (Yes, no. or unknown) Unk.	/ER IN U.S. ARMED FORCES? (If yes give wor or dotes o	of service)	-20-2632	Records, Spri	Add ngfield State	
	DEATH (Enter only one cou ATH WAS CAUSED BY: IMMEDIATE CAUSE	Massiw	4 11	al pneumonia		INTERVAL BETWEEN ONSEL AND DEATH OAVS
1 2 2 2 2 2 2	IMMEDIATE CAUSE	(a)	o olla oct	ar pheumonia		/ days
Conditions, if an rise ta immedia stating the und	y, which gave atte couse (a),	TO (b)	0 0220 001	al pheumonia		, uays
rise to immedia stating the und last.	y, which gave the couse (a), lerlying cause Significant conditions of	(0) (0) (0) (0) (0) (0) (0)	FATH BUT NOT RELATI	ED TO THE TERMINAL DISEASE COL	NOITION GIVEN IN PART 1(o) Sychotic reac	19. WAS AUTOPSY PERFORMED?
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rise to immedia stating the und lost. PART II. OTHER CBS ass 20a. ACCIDENT W OR CONTRIBUTIN (IF EITHER, NOTIF Haur of IN Haur of In Saw the company to the	y, which gave ate couse (a), erlying cause SIGNIFICANT CONDITIONS COURTS OF DEATH AS UNDERLYING AS UNDERLYING AS UNDERLYING AS UNDERLYING AND AUSE OF DEATH AY MEDICAL EXAMINER) JURY Manth, Day, Year JURY Manth, Day, Year Jury that (I) (this has deceased alive on	(b) 10 (c) ONTRIBUTING TO D TO DESCRI	EATH BUT NOT RELATI TERIOSCI BE HOW INJURY OCCU Y OCCURRED On Not While of wark The deceased from	ED TO THE TERMINAL DISEASE CO Prosis, with po JRRED. (Enter nature of injury in De. PLACE OF INJURY (Hame, farm factary, street, affice bldg., etc.	Port I or Part II of item 18.) 1. 20f. (City ar tawn)	tion 19. WAS AUTOPSY PERFORMED? YES NO E
rise to immedia stating the und lost. PART II. OTHER CBS ass 20a. ACCIDENT W OR CONTRIBUTIN (IF EITHER, NOTHE THE THER, NOTHE SAW the Cas with the Cas of the Cas o	DUE y, which gave ate couse (a), erlying cause SIGNIFICANT CONDITIONS COUNTY CONDITIONS COUNTY CONDITIONS COUNTY	(b) 10 (c) ONTRIBUTING TO D TO DESCRI	EATH BUT NOT RELATI TERIOSCI BE HOW INJURY OCCU Y OCCURRED On Not While of wark The deceased from	ED TO THE TERMINAL DISEASE COPEROSIS, with property of injury in De. PLACE OF INJURY (Hame, farm factory, street, affice bldg., etc. arm 6-13-63, and that death accurred affice. ATTENDING PHYS.	Port I or Part II af item 18.) 1. 20f. (City ar tawn) 10:30 M, fram causes MED. STAFF DIRECTOR STAFF PHYS. [tion 19. WAS AUTOPSY PERFORMED? YES NO X (Caunty) (Stote) 7, 19, that (I) (we) last and an the date stated above 22b. DATE SIGNED 10-10-67
rise to immedia stating the und lost. PART II. OTHER CBS ass 20a. ACCIDENT W OR CONTRIBUTIN (IF EITHER, NOTIFE) 20c. TIME OF IN Hour of Saw the c 22a. SIGNATUR	y, which gave ate couse (a), erlying cause DUE SIGNIFICANT CONDITIONS CO SOC WITH CO AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER) JURY Manth, Day, Year	(b) 10 (c) CONTRIBUTING TO D TEORAL A 20b. DESCRII 20d. INJUR While of work Dital) attended 10-10-67	EATH BUT NOT RELATI PTERIOSCI BE HOW INJURY OCCU Y OCCURRED Not While at wark the deceased fro	DED TO THE TERMINAL DISEASE COLOR PLACE OF INJURY (Hame, farm factory, street, affice bidg., etc. arm 6-13-63 , and that death accurred affice bidg. ATTENDING DELTA ATTENDING	Port I or Part II af item 18.) 20f. (City ar tawn) 10:30 M, fram causes	19. WAS AUTOPSY PERFORMED? YES NO EX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Page should be filed with the State Dept. af Health priar ta burial, cremation, or removal, and in any event, within 22 haurs Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2d Film #G394 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death funeral s 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY Baltimore o. COUNTY Carroll o. STATE Maryla nd MARYLAND by the f Pages ours afte b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Baltimore, Maryland 21231 8vrs. 8monsludavs Sykesville, Maryland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS 2208Fleet St. e. IS RESIDENCE ON A FARM? n popers ithin 72 Springfield State Hospital Sykesville (/Maryland YES NO K NAME OF Middle DATE Month Year Dov complete DECEASED corbi Felix Joseph Kryger 10 1967 (Type or print) DEATH IF UNDER 24 HRS S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years last birthdoy)
Yrs. Months 5-30-06 Hours Male White any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removo Michael Kryger Marynna Koscinski 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 0 215-18-9063-ASpringfield Hospital Records. Sykewville unknown 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY Hours DEATH Mesenteric Thrombosis IMMEDIATE CAUSE (o) þ DUE TO signed burial Pulmonary Conditions, if ony, which gove Emphysema Years rise to immediate cause (a), DUE TO stoting the underlying couse or ottending this certificate hos been Obesity Years 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) Schizophrenic Reaction, Catatonic Type. NO K 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) the hospital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. Not While foctory, street, office bldg., etc.) ot work FUNERAL DIRECTOR: After TO HOSPITAL OR ATTENDING Poge 4 may be retained by 21. I certify that (this haspital) attended the deceased from 1-26-59 saw the deceased glive on 10-14od fram 1-26-59 , 19-59, to 10-14 , 167, that (x) (we) last , and that death occurred at 25AM, from causes ond on the dote stated above. saw the deceased alive on 22b. DATE SIGNED 220 SIGNATURE Suha Ozgun M.D. 22d. ADDRESS 22c. PHYSICIAN'S Suha Ozgun NAME (Type) director, 23b. DATE THEREOF 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 2 10-18-1967 Holy Rosary Baltimore County, Maryland 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) Lilly & Zeiler Inc. 1901-07 Eastern Avenue 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13715 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY o. STATE MARYLAND MARYCADI Pages filled in by the b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)138TILLINSTIST Box 153 e. IS RESIDENCE NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ban perpers within 72 b ON A FARM? Union Bridge, Md. YES NO NAME OF 4. DATE Doy Year Last the attending physician and completely sit permit. Then please remave carbar carbar DECEASED 10 1967 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF lost birthdoy) Months Hours Doys WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. 8 RTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? pup 'ARROLL COUNTY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service 6 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c).)
PART I. DEATH WAS CAUSED 8Y: burial-transit ONSET AND DEATH DENEATURIT. IMMEDIATE CAUSE (o) DUE TO signed Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse be retained by the haspital ar attending as the priar ta O FUNERAL DIRECTOR: After this certificate has been lost WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health CERTIFICATION 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Yeor Hour om foctory, street, office bldg., etc.) Not While State ATTENDING ot work 21. I certify that (1) (this hospital) attended the deceased from 10 165 7, that (1) (we) las shauld and that doth occurred off so the from causes and on the date stated above 1967 saw the deceased olive on. 220. SIGNATURE 22b. DATE SIGNED STAFF **ATTENDING** DIRECTOR PHYS. , page , filed PHYSICIAN'S 22d. ADDRESS NAME (Type) Sherman, Chang, M. D. Westminster. Md. directar, shauld 23c. NAME OF CEMETERY OR 23d. LOCATION (City or Town) BURIAL, CREMATION 23b. DATE THEREOF REMATORY (County) REMOVAL (Specify) County Gen. Hosp. Westminster Carroll Md Carroll Disposed by Hosp. 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 GLENN A. FISHER Administrator

MARYLAND STATE DEPARTMENT OF HEALTH

2.1551 81082 SHIS RELECT THE STREET OF THE STREET Children Como Hora Co THE RESERVE TO SERVE BASY CIES OI TAYLUARE I 10/19/01 CALLESS COURTS JOHN ALLEN (ESCALLEST CELACE, MANCE THE REPORT DIST things of mean of the former country the tree establish Carrell lid. TOREST BEILDING WEST AND THE STATE OF

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13718

CERTIFICATE OF DEATH

			CEKTIFICA	IE OF DEATH					
PLACE OF DEATH				2. USUAL RESIDENCE	(Where deceosed lived, if institu	ition: Residence before od	mission)		
Carroll			MARYLAND	o. STATE	Pal timena				
	(If outside corporate limits,		c. LENGTH OF STAY IN 1b	C CITY OF TOWN (I	rland outside corporate limits, write RI	Baltimore C			
write RURAL a	id give nearest town)		LENGTH OF STATE IN TO			TKAL OLD GIVE LIEULEST TOA	/II)		
write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit			1 day	Baltimo	re		Decinence		
		,		d. STREET ADDRESS		e. IS	RESIDENCE A FARM?		
Spring.	field State	Hespita	1	2504 Mc	ore Ave.	YES	☐ NO 5		
NAME OF	First	t	Middle	Lost	4. DATE Mor	nth Doy	Year		
Type or print)	SAR	AH	HELEN	LEBO	OF DEATH OCTO	BER 27,	19 67		
SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH		IF UNDER 1 YEAR IF L	NDER 24 HR		
Female	White	WIDOWED T	DIVORCED	9-11-1876	9. AGE (In years last birthdoy) 91 yrs.	Months Doys Ho	urs Min		
	N (Give kind of work done	10b. KIND	OF BUSINESS OR	1 7	nty & Stote, or foreign country)	12. CITIZEN OF WH	AT		
ng most of workin	life, even if retired) worker	SINDU	e Mfg.			COUNTRY?	A .		
FATHER'S NAME	A MOLVEL	2110	a HIR.	14. MOTHER'S MAIDE	lvania	0.5.	А.		
	Marsh 1	T 77 "	7						
-Unkn o				Unknov					
WAS DECEASED EV	ER IN U.S. ARMED FORCES? (If yes give wor or dotes of	service) -		7. INFORMANT	Add				
No	((g	183-	12-2103-A	Records, Spr	ingfield State	Hospital			
	EATH (Enter only one couse	e per line for (o), (b), ond (c).)	H=1 F=12		INTERVA	L BETWEEN		
PART I. DE	ATH WAS CAUSED BY:	Arteri	osclerotic	heart diseas	ia.	ONSET	ND DEATH		
4200	DUE T								
Conditions, if on			hopneumonia			n	avs		
rise ta immedia	Te cause (a), (nophe unon La				ay b		
stoting the und	erlying couse								
		c)				I lo was	AUTORCY		
PART II. OTHER	SIGNIFICANT CONDITIONS COL	NIKIBUTING TO	DEATH BUT NOT RELATED	O THE TERMINAL DISEASE	CONDITION GIVEN IN PART 1(o)		AUTOPSY ORMED?		
						YES [NO [
	AS UNDERLYING	20b. DESCI	RIBE HOW INJURY OCCURR	ED. (Enter noture of injury	in Port I or Port II of item 18.)				
	G CAUSE OF DEATH MEDICAL EXAMINER)								
20c. TIME OF IN	JURY Month, Doy, Yeor	2Dd. INJU		PLACE OF INJURY (Home, f		(County)	(Stote)		
Hour o	.m. 19	While of work	Not While of work	foctory, street, office bldg., e	etc.)				
	ify that (1) (this hasp			10-26-67	10 to 10-27	-67 , 19, that	1) (240) [
saw the	leceased alive an	0-27-67	a me deceased main	hat death accurred	, 191:20 ^{ta} AM 10-27 at M, from causes	and an the date st	ated abo		
220. SIGNATURE			, unu i	ilai dealli decolled	u1M, Holli cuoses	22b. DATE SIGNED	uleu ubu		
111	,	- 1	101	M.D. PHYS.	MED. STAFF DIRECTOR PHYS.	x 10-27-67			
D.T. U									
22c. PHYSICIAN' NAME (Typ		Glahn	M/ D.		-L0		_		
					ykesville, Mar				
BURIAL, CREMAT		REOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City or T	own) (County)	(Stote)		
REMOVAL (Specific Burial	10-30	-67	Mt. Zior	1	Carlisle		Pa.		
4. FUNERAL DIRECT	OR		Mt. Zior	2So. R		REGISTRAR'S SIGNATURE	-		
M. Jeni	cins & Sons	s Co.li	905 York I	Rd. Ballton	OT SO WET	Waster Yu	AAR.		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled-in by the furnished director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon capers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, ar remaval, and in any event, within 72 hays after death. Page 4 may be retained by the haspital or attending physician. VR A15 (4) 25M 1/67

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

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CERTIFICATE OF DEATH

			CER	IIIICAIL	OI DEATH				1	TREE .
1.	PLACE OF DEATH				2. USUAL RESIDENCE	CE (Where deceosed			ce before	odmission)
	o. COUNTY	arroll		MARYLAND	o. STATE Mary	rla nd	b. cou	NTY Bal	timor	e
	b. CITY OR TOWN (If outside corporate limits,			c. CITY OR TOWN (I	If outside corporote	limits, write RU			
	Rural S	give nearest tawn) ykesville	46 yrs	10 mo	City, Ba	ltimore				30-4
	d. NAME OF HOSPIT	AL OR INSTITUTION (If not	in hospitol, give street oddress)	d. STREET ADDRESS				е.	IS RESIDENCE
		eld State Ho			731 E. 2	2nd Stre	et			ON A FARM?
_	NAME OF	Firs			Lost	4. DATE	Mon	ith	Doy	Year
	DECEASED (Type or print)	Edward	Josep	h	Lynch	OF DEATH	10)	7),	19 67
S.	SEX	T	7. MARRIED NEVER MAR		B. DATE OF BIRTH		AGE (In years	IF UNDER		F UNDER 24 HRS
Ma	le	White	WIDOWED DIVO	RCED	12 - 15 -	1881	lost birthdoy) 82 yrs.	Months	Doys	Hours Min.
100	D. USUAL OCCUPATION	(Give kind of work done	10b. KIND OF BUSINESS C)R	11. BIRTHPLACE (Cou				TIZEN OF V	VHAT
dui	ring most of working Brakema:	life, even if retired)	Rail Rea	1	Marylan	nd		(0	OUNTRY?	U.S.A.
13	. FATHER'S NAME	4	1,000		14. MOTHER'S MAID		1100		1111	V
	Martin	J. Lynch			Mamr Sh	annahan				
15	. WAS DECEASED EVE	R IN U.S. ARMED FORCES?	16. SOCIAL SECURITY N	IO. 17. II	NFORMANT	recilitatient.	Addr	ress	COL	
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H		EATH (Enter only one cous	se per line for (o), (b), ond (c).)	CZ TOPI	TIGITOTO	HOSPINGT	record	Oy.		VAL BETWEEN
r	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (Hoomt foil	ure					ONSET	AND DEATH
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	PART II. OTHER SI	GNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT NOT	RELATED TO T	THE TERMINAL DISEASE	CONDITION GIVEN	IN PART 1(o)		19. W	AS AUTOPSY ERFORMED?
TIO	Schiz		action, Hebeph						YES	X NO
CERTIFICATION	20o. ACCIDENT WA	S UNDERLYING	20b. DESCRIBE HOW INJUR			y in Port I or Port	II of item 18.)			
		CAUSE OF DEATH MEDICAL EXAMINER)								
MEDICAL	20c. TIME OF INJ	URY Month, Doy, Yeor	20d. INJURY OCCURRED		CE OF INJURY (Home,		(City or town)	(Co	unty)	(Stote)
MEL	Hour o.	10	While Not While	focto	ory, street, office bldg.,	etc.)				
1	21 L certi	for that 1/1) (this hash	oital) attended the deceas	sed fram	Dec 15	, 19 19, to	10-1/1-	196	7, tho	X) (we) la
	saw the d	eceased alive on	10-14- 19,67	_, and that	t death occurred	at 10: 45 PM	Fram couses	and an th	he date	stated abav
	22o. SIGNATURE	MIT	01/1		ATTENDING	MED.	CTAFE	22b. D.	ATE SIGNED	
		Clans	1 a fair	M.D		DIRECTOR [STAFF PHYS. 5	20-	15.6	7
	22c. PHYSICIAN'S NAME (Type	Octorio	Ruiz, M.D.		22d. ADDRESS	N-13 CL	de II			ville,
	NAME (Type	OCCAVIO				field Sta			Mary	Land
23	o. BURIAL, CREMATI REMOVAL (Specify	ON, 23b. DATE THEF	1,000	CEMETERY OR	1 //		ATION (City or To	. 0	(County)	Per Evela
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2	4. FUNERAL DIRECTO	R	ADDRESS ADDRESS	. 1 -		REC'D BY REGISTRA		EGISTRAR'S S		1.0
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A STATE OF THE ASSESSMENT

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **EOR STATE** HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY_ o. STATE Carroll Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL ond give neorest town) B altimore Rural-Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 110 N. Calhoun Street YES NO S "be executed within 24 haurs after death." "pending" in pencil in Item 18, Girc-Rage 3. NAME OF First Middle 4 DATE Day DECEASED HARVEY (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Dovs White Male WIDOWFD [July 29, 1935 DIVORCED 72 hours after death 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Carroll Co., Md. Registered Nurse 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Ralph D. Maring Bessie W. Pickett 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service any event within 218-32-9076 Mr. Ralph D. Maring Westminster INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line top (o), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: This certificate should I please execute the certificate, writing the ward director. Page 4 should be farwarded to the Ch DUF TO alell Conditions, if ony, which gove rise to immediate couse (a), DUF TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO. 20o. EXTERNAL CAUSE WAS 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH. Cucel Gun at-MT ans 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town (Stote) Roccised, office blod., etc.) While Not While of work may be retained far your FUNERAL DIRECTOR: Page While of work 21. I certify that I taok charge af the remains described above, held an Autopsy ____, Inspection X Inquiry . ond in my opinion deoth resulted from: Noturol couses Accident Suicide X Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED prior 1 ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Glenn Spei NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL CREMATION (County) 0 Winfield Church Of God Carroll 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5) C. M. Waltz Box 241 Sykesville, Md. 6M 1/67

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CERTIFICATE OF DEATH

13722

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e de de		S. :	Type ar print)	6. COLOR OR RACE	BUR 7. MARRIED	HARRIS NEVER MARRIED		MARTIN DATE OF BIRTH	DEAT	9. AGE (In years	I IF UNDER	LYEAR LIF	19 6° UNDER 24	
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th certification in the Then removo			Inknown				1	Unknown			dress			
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requires that the deoth certificate be executed within 24 hours after deoth g physicion. signed by the attending physicion and completely filled in by the funeral burial-transit permit. Then please remove tarban, papers. Pages in order burial, cremotion, or removol, and in ony event, within 72 hours after deoth			18. CAUSE OF D	DEATH (Enter only one con ATH WAS CAUSED BY:									AL BETWI AND DEA	
that on. by the ransi			FART I. DE	IMMEDIATE CAUSE	(a) Arter	ioscleroi	tic ca	rdiovascu	lar d	isease		year	CS	
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The law rattending has been the as the hardento		N	PART II. OTHER S	ignificant conditions of brain synd	CONTRIBUTING TO	DEATH BUT NOT REL	ATED TO THE	E TERMINAL DISEASE C	ONDITION G	IVEN IN PART 1(a)	th	19. WA	S AUTOP RFORMED	?
	2	CERTIFICATION	psycho	tic reaction	n.						011	YES	N) 5
IAN: ral or ficote for us		E		AS UNDERLYING ☐ G ☐ CAUSE OF DEATH	20b. DESC	RIBE HOW INJURY OF	CCURRED. (Er	nter nature af injury i	in Part I or I	Port II of item 18.)				
rsic spill spill rearti hed t. of				Y MEDICAL EXAMINER)										
PHYS ne hosp this cer etache etache		MEDICAL	20c. TIME OF IN	JURY Manth, Doy, Year	20d. 1NJU While	IRY OCCURRED		OF INJURY (Home, fa		. (City ar town)	(Co	ounty)	(St	ote)
Of top		W	p	.m. 19	at wark	Nat While at wark			*					
After be Sto			21. 1 cert	ify that (M) (this had	spitol) ottende	d the deceased	from_M:	y 16,	19 67	to Octobe	r 9, 19	67, that	(X(w	e) las
Necined In the the			sow the o	deceosed olive on C	ctober	19 67,	ond that	deoth occurred o	o#1:20	AM from couse	s ond on t	he dote s	toted	obove
OR ATTENI be retained DIRECTOR: A je 3 should ed with the			220 SIGNATURE	Day Non	111.0	nelles	1	ATTENDING	MED.	STAFF		ATE SIGNED		
y be ry be radge 3 filed v			Trece	rea rege	esyla	er p	CM.D.	PHYS.	DIRECTOR			9-67		
ral o loy be al DII	3		22c. PHYSICIAN NAME (Typ	1		** 5				field St				
O HOSPITAL Page 4 moy O FUNERAL director, pag should be fi	- 1			ourran wac						ille, Ma				
Page 4 FUNE director should		230	BURIAL, CREMAT	ION, 23b. DATE TH	1 1 1	23c. NAME OF CEME	1	m 3		LOCATION (City or	lown)	(County)	1 (Sto	ie)
TO HOSPITAL OR ATT Page 4 moy be retain TO FUNERAL DIRECTO director, page 3 shot should be filed with			BREMOVAL (Specif		-1-61	Freed	om	Cemeter	CID IDY DECT	YKESVII	REGISTRAR'S S	SICMATURE	1119.	
	00	24	FUNERAL DIRECT	Ill Hairly	1 1.1.	ADDRESS	Mid	/	C'D'BY REGI		_	_	100	
VR A15 (4) 25M 1/67	1861		ACHON C	N. Hulina	syl	wille,	1106.	DATIO	C! 2:	1967	Ochon	CEA Acc	Special Contract	

RESIDENCE CAL UNCONSTRU In tomore delice win in a root at troop of the State of t in I may weet the some I in it.

13720 by the funeral Pages 1 and 2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

Page 4 may be retained by the haspital or attending physician.

VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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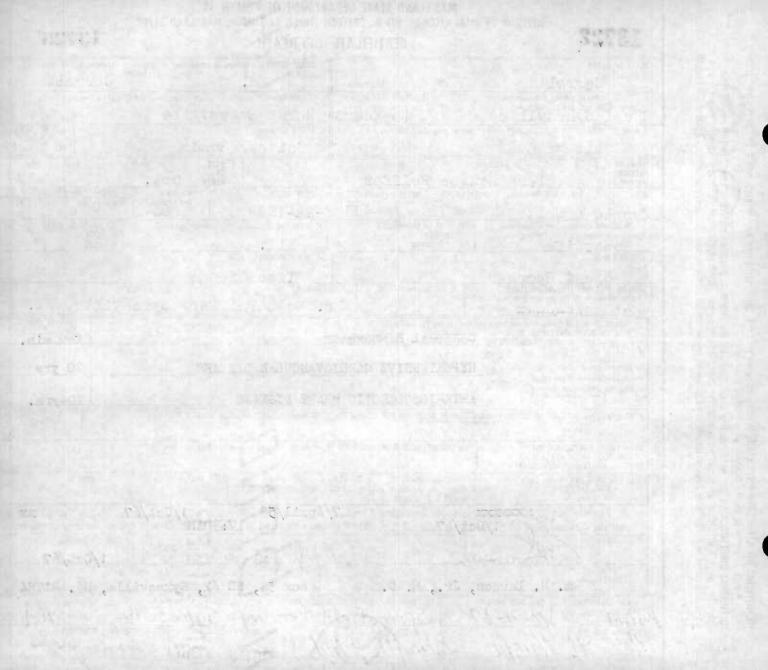
1.	PLACE OF DEATH a. COUNTY			MARWA		2. USUAL RESIDENCE (V		b. COUN	TY		, ,
-	b. CITY OR TOWN	(If autside carparate limit	5.	MARYLAN C. LENGTH OF STAY IN 11		Maryla	tside carparate li			ore Ci	
	Sykesvil	d give nearest tawn)		3yrs.25dys.		Baltin			3	2	0 4
		TAL OR INSTITUTION (If n	ot in haspital,			d. STREET ADDRESS				e. IS	RESIDENCE A FARM?
L	Springfi	eld State F	iospita	1		1104 W.	40th St		1.29	YES	NO DE
3.	NAME OF DECEASED		rst	Middle		Last	4. DATE OF	Montl	h	Day	Year
	(Type or print)	+	EPH	₹.		MINITOR	DEATH	OCTOB			19 67
	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED		DATE OF BIRTH		GE (In years st birthday)	IF UNDER I		NDER 24 HRS.
I,	Male	White		Sep - DIVORCED		12-22-1899	67	yrs.	indining	buys III	015 (1111).
du	a, USUAL OCCUPATIO ring mast of warking NODE	N (Give kind af wark dane Life, even if retired) Naul Gr		ind of Business or IDUSTRY Cab Company	7	11. BIRTHPLACE (County Maryland 14. MOTHER'S MAIDEN N		cauntry)	COI	IZEN OF WHA	AT
		wa- Mechael	Minit	or		Unkı		Cress			
15	. WAS DECEASED EV	ER IN U.S. ARMED FORCES?	16.	SOCIAL SECURITY NO.	17. IN	FORMANT	IOMII	Addre	SS		
()	es, no, or unknawn) Unknown	(If yes give war ar dates	of service)	3-10-2657-A			ngfield			ital	
2	Conditions, if ony rise to immedia stating the underlast. PART II. OTHER S	te cause (a), erlying cause IGNIFICANT CONDITIONS ((b) 10 (c) Infe	cted gangren	D TO TH	E TERMINAL DISEASE COM	IDITION GIVEN IN			Mont	AUTOPSY FORMED?
CERTIFICATION	CBS ass			arterioscle					ion	YES 2	
CERTII	OR CONTRIBUTING	G CAUSE OF DEATH MEDICAL EXAMINER)	200. De	SCRIBE HOW INJURY OCCUI	KKED. (E	nter notore at injury in	ran i or ran ii o	or nem ro.)			
MEDICAL	p.	m. 19	While at war	Nat While at work	factor	OF INJURY (Hame, farm y, street, affice bldg., etc.)		ty ar tawn)	(Cau		(State)
	21. I cert	ify that (I) (this hos leceased alive an_1	pital) atten .0-25-6	ded the deceased fra 719and	m_9 that	-30-64 ,) death accurred at	3:35 AM	10-25-6 om causes (57 , 19 <u> </u>	, that (ne date sto	l) (we) las ated abave
	22o. SIGNATURE	Claris	al	ang	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	10-2	TE SIGNED	
	22c. PHYSICIAN'S NAME (Type		A. Rui	z, M.D.		22d. ADDRESS Sp Sy	ringfie kesvill	e, Mary	yland	spital	
23	a. BURIAL, C REMATI REMOVAL (Specif		EREOF 67	23c. NAME OF CEMETER		al	Ba	ON (City or Tov		(County)	(State)
2	4. FUNERAL DIRECTO	It Seitz	. 814	H36 St Ba	et-	City Ma DA OCT	3 0 19		CUSTRAR'S SI		ge.

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RTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13722 13725 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death unerol 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town ar al Syrcesvill Rural Sykesville Years d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Gaither Road Gaither Road YES NO NAME OF Middle and completer fremave carbon n any event with Last 4. DATE Day Year DECEASED 1967 Louise Peiffer (Type or print) Clara Oct. DEATH 9. AGE (In years S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Months Days Hours 8-23-1899 WIDOWED DIVORCED Female 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? removal, and Housewife Tome 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Elize Tietze Oscaf Sperber WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war ar dates of service) buriol, cremation, or Sykesville, Md. Mr. Webb Peiffer 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH CEREBRAL HEMORRHAGE IMMEDIATE CAUSE (a) 4200 Canditians, if any, which gave HYPERTENSIVE CARDIOVASCULAR DISEASE 20 yrs rise to immediate cause (a), DUE TO stoting the underlying couse hos been (c) ARTERIOSCLEROTIC HEART DISEASE O HOSPITAL OR ATTENDING PHYSICIAN: The low 20+vrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? NO YES 🗌 certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2Do. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) While Not While factory, street, office bldg., etc.) ot wark ot work saw the deceased dive on 1/Oct/67 19 , and that death occurred of 7:304 Mrom causes and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED director, page 3 DIRECTOR PHYS. M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Wm TO FUNERAL Box 54. Lawson, Jr. M. D. RD #2. Sykesville, Md. 23o. BURIAL CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (State) REMOVAL (Specify) Sukesville 2So. RECO BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) rcharles 25M 1/67



OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. COUNTY b. COUNTY CARROLL MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) a. IS RESIDENCE ON A FARM? YES NO Z DECEASED DEATH (Type or print) 19 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days WIDOWED T DIVORCED T 12. CITIZEN OF WHAT COUNTRY 1Db. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO. | 17. INFORMANT Address SAME (If yes give wer or dates of service) ADDRESS INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Interioscherotie skart Disease Conditions, if eny, which' gave rise to immediate cause DUE TO (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? YES NO [20e. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Pert II of item 18.) OP CONTRIBUTING CAUSE OF DEATH MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Dey, Year fectory, street, office bldg., etc.) While Not While Hour em at work at work 1963 to Oct. 3, 1967, that (1) (we) last saw the deceased alive on OCT3, and that death occured and M, from the causes and on the date stated above. 22b. DATE SIGNATURE SIGNED death. Page A DIRECTOR PHYS. M.D. 22d. ADDRESS NAME (Type) NAME OF CEMETERY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. REMOVAL (Specify) 0:58 EUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

PELLINGE FIRSTER Orthrodowskie Heart Brancon 13 det 3, 1167 50 CH2/09 #201 12/ HARSHEY MS JUMP 2 1 190 - M. Sterrentes W. Caller C. S.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13724 CERTIFICATE OF DEATH death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) in by the funera o. COUNTY Carroll Maryland physicion. signed by the attending physician and completely miled in by the fun buriol-transit permit. Then please remove corban papers. Pages I buriol-transit permit or removal, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside carporate limits, C. LENGTH OF STAY IN 16 write RURAL and give nearest town)
Sykesville mos. Baltimore 7yrs. ludys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Springfield State Hospital 514 E. Pratt St. 3. NAME OF First Middle 4. DATE DECEASED REINFELTS JOSEPH (Type or print (NMN) DEATH S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** 5-10-1890 Sep. DIVORCED Male White

24 hours after

requires that the deoth certificate be executed

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O FUNERAL DIRECTOR: After

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attending

O HOSPITAL OR ATTENDING PHYSICIAN: 1 Poge 4 may be retained by the hospital or

b. COUNTY Baltimore City c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARMS YES NO x Day Year OCTO BER IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. birthday) Manths Days Hours 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign cauntry) 12. CITIZEN OF WHAT during most of working life, even if retired)

Porter (retired) INDUSTRY COUNTRY? Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Reinfelts Birdie Killmayer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) 212-12-7125 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY Y ONSET AND DEATH Cor Pulmonale IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave Pulmonary emphysema Years rise to immediate cause (a). DUE TO stoting the underlying couse last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART 1(o) assoc. with other CNS syphilis, without qualifying phrase, arrested pulmomry tuberculosis NO K 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) factory, street, office bldg., etc.) at wark at wark 21. I certify that (1) (this hospital) attended the deceased fram 11-20-59 19___, that (I) (we) last M. from causes and on the date stated above. saw the deceased alive an 10-4-67 19 and that death accurred of 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF PHYS. 10-5-67 M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital NAME (Type) Octavio A. Ruiz, M. D. Sykesville, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) Burial (Specify) 10/7/67 Holy Redeemer Cemetery Baltimore, Md. 24. FUNERAL DIRECTOR ADDRESS 2Sa. REC'D BY REGISTRAR Ullrich Funeral Home 4210 Belair Road.

13727

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W. Harold Fredlock Piedmont, W.Va.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13729

13725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

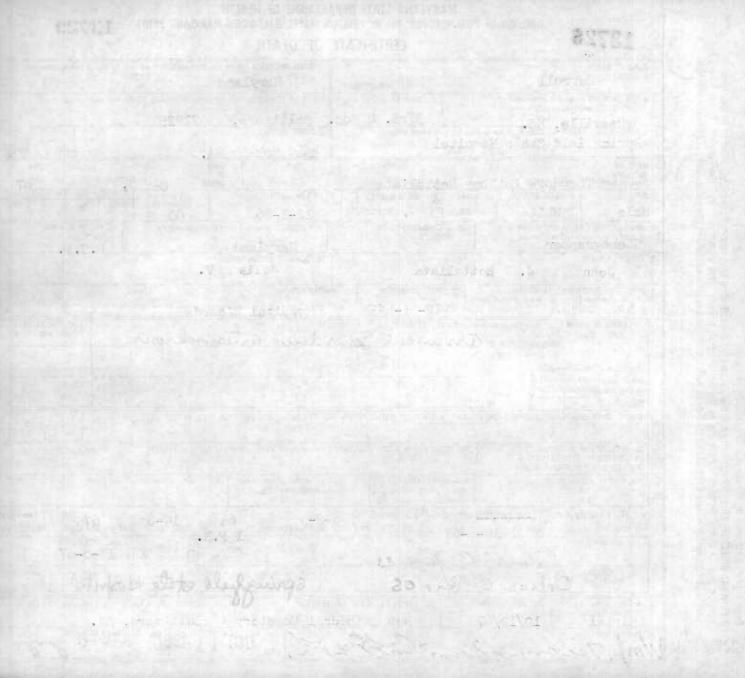
Page 4 may be retained by the haspital or attending physician.

VR A15 (4) (25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any event-within 72 haurs after peaths.

CERTIFICATE OF DEATH

. PLACE OF DEATH	II		
	2. USUAL RESIDENCE (Wh	ere deceosed lived, if institution: R b. COUNTY	esidence before odmission)
o. COUNTY Carroll MARYLAND	o. STATE Maryla	nd	/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outsi	de corporote limits, write RURAL or	nd give neorest town)
2Vm Wo	Baltimore.	21,229	30-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	In the late Late Late Late Late Late Late Late L	e. IS RESIDENCE
Springfield State Hospital	4649 Rokeby	Rd.	YES NO NO
3. NAME OF First Middle DECEASED		4. DATE Month	Doy Year
(Type or print) Theodore Anthony Rettaliata		DEATH Oct 8.	19 67
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years IF U	NDER 1 YEAR IF UNDER 24 HRS
Male White WIDOWED DIVORCED	12-1-86	lost birthdoy) Moi	nths Doys Hours Min.
0o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County & S	itote, or foreign country)	12. CITIZEN OF WHAT
luring most of working life even if retired) Stenographer INDUSTRY	Maryland		COUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NA	ME	UASARA
John J. Rettaliata	Julia	V.	
IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT	Address	
(Yes, no, orrunknown) (If yes give wor or dotes of service)	Howit.7 D		
	Hospital R	ecords	INTERNAL DETWEEN
18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY:	1 · 1 · f	- n.	ONSET AND DEATH
IMMEDIATE CAUSE (0) CLOSTON CE OF Jew	raliced and	erusclesis	
4500 DUE TO			
Conditions, if ony, which gove) (b)			
rise to immediate couse (o), stoting the underlying couse DUE TO			
lost. (c)			
DADY II OTHER CIGNIFICANT COMPLYING CONTRIBUTING TO DELTH BUY NOT DELATED TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDI	TION GIVEN IN PART 1(o)	19. WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDI	TION GIVEN IN PART 1(0)	PERFORMED?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO			19. WAS AUTOPSY PERFORMED? YES NO
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13730

CERTIFICATE OF DEATH

requires that the deoth certificate be executed within 24 hours after deoth glaysician. signed by the attending physicion and completely filled in by the funeral burial-tronsit permit. Then please remove carbon popers. Pages frank burial, crematian, or removal, and in ony event, within 72 hours offerdean burial, crematian, or removal.		LACE OF DEATH		-32			2. USUAL RESIDENCE (V a. STATE	Where deceosed liv	b cou	INTY	The Spinster, or	
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by P.C.		write RURAL and give r Sykesville	,	(byrs.5mos	.8dys		re		5		30-4
4 ho ers. 72 h	1	. NAME OF HOSPITAL OR	INSTITUTION (If no	nt in haspital, g	ive street oddress)		d. STREET ADDRESS				е.	IS RESIDENCE ON A FARM?
nin 24 hours aft filled in by the popers. Page, min 72 hours of		Springfield	State H	ospita.	1.		107 Albeman	rle St.			YES	NO X
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equires that the physician. signed by the burial-tronsit burial, cremat		Canditians, if any, which rise to immediate caus	gove)	(b) Gene	ralized a	rteri	osclerosis		145			Years
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e low re trending as been os the prior to		last.		(c)								
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AN: The contract of the contra	CATIC										YES	□ NO 🔀
PHYSICIAN: e hospital or nis certificate stoched for us Dept. of Healt	MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDER OR CONTRIBUTING □ CAU	RLYING SE OF DEATH	20b. DE:	SCRIBE HOW INJURY	OCCURRED.	(Enter nature of injury in	Part I ar Part II a	f item 18.)			
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G PHYSIC the hospi r this certi detoched te Dept. of	EDIC	20c. TIME OF INJURY M	onth, Doy, Year	160.3	Not While		CE OF INJURY (Home, farm tary, street, affice bldg., etc.)		y ar town)	(Cau	nty)	(State)
ING by th ter t	×	p.m.	19	at wark	UI WUIK	130	,,					
0		21. I certify the	at (I) (this hos	pital) attend	ded the deceased	fram	4-27-61,1	9 PMIC	-5-67	, 19	$_{-}$, that	(I) (we) last
OR:		saw the decease	ed alive an	LU-5-01	19,	and tha	t death accurred at	2:00 M, tro	im causes			
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13731

13728

CERTIFICATE OF DEATH

3. NAME OF DECEASED First Middle Lost 4. DATE Month Day Year DECEASED COTOBER 11. 19. COTOBER 11.	- NE			2000			CLICITI	CAIL	VI DEATH				
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DEFINITION OF THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Schizophrenic reaction, paranoid type 20a. Accident was underlying Cause of Death Or Contributing Cause of Death Or Contribu						TO							
Schizophrenic reaction, paranoid type Schizophrenic reaction, paranoid type	マニ きまっ)	(c)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Hour a.m. p.m. 19 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 21. I certify that (I) (this haspital) attended the deceased fram 7-11-18, 19 22c. SIGNATURE 22c. SIGNATURE 22d. ADDRESS 22d. ADDRESS 23d. BURIAL, CREMATION, REMOVAL (State) 23a. BURIAL, CREMATION, REMOVAL (State) 23a. BURIAL, CREMATION, REMOVAL (State) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or town) (County) (State) 45 45 46 47 47 47 47 47 47 47 47 47 47 47 47 47			z	PART II. OTHER SI	GNIFICANT CONDITIONS C	ONTRIBUTING T	O DEATH BUT NOT RELA	TED TO	THE TERMINAL DISEASE CO	NDITION GIVEN IN PA	RT 1(a)	19.	WAS AUTOPSY PERFORMED?
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The state of the s	fical for for He		TIFIC	20a. ACCIDENT WAS	UNDERLYING	20b. DE	SCRIBE HOW INJURY OCC	URRED.	(Enter nature of injury in	Part I or Part II of ite	am 18.)		
21. I certify that (I) (this haspital) attended the deceased fram 7-11-18, 19 to 10-11-67, 19, that (I) (we) saw the deceased alive on 10-11-67 19, and that death occurred at 1:30 MA from couses and on the date stated ob 220. SIGNATURE 220. SIGNATURE 220. SIGNATURE 220. SIGNATURE 220. DATE SIGNED 10-18-67 PHYS. 220. Physician's NAME (Type) Antonius Glahn, M. D. 220. ADDRESS Springfield State Hospital Sykesville, Maryland 230. BURIAL (REMATION, REMOVAL (Specify) 20-20-67 Freedom Cemetery Or CREMATORY 23d. LOCATION (City or Town) (State) Sykesville Mad	SIC spiit erti erti sed t. of												
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Saw the deceased alive on 10-11-67 Saw the deceased alive on 10-1	de the		ME		10			TOCT	ary, street, office blag., etc.	, , , , , , ,			
Saw the deceased alive on 10-11-67 Saw the deceased alive on 10-1	Afte be Sto			21. I certi	fy that (1) (this has	pital) attend	led the deceased f	ram	7-14-48 ,1	19tq 10-	-14-67,1	19, th	at (I) (we) last
236. BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or lown) (County) (State) PREMOVAL (Specify) 10 - 20 - 67 Freedom Cemetery Suke suille Md					eceased alive on_1	0-14-6	719, ai	nd that	t death occurred at	11:30 MA from			
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24 FINIFAL DIRECTOR ANDRESS 250/ RECD BY REGISTRAR 25h REGISTRAR'S SIGNATURE	HO Be Be rect rect		230	BURIAL, CREMATIC	1		1		A 1			(County)	(State)
24 FUNFRAL DIRECTOR A A ADDRESS 1 250/ REC'D BY REGISTRAR 1 256 REGISTRAR'S SIGNATURE	5 5 5 P		1	DUCIAL	10-0	0-67	Freed	3M	Cemetery	SyRe	SUILLY.	NE CIONATUR	IVId
VR A15 (4) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0	26	. FUNERAL DIRECTO	11 Ylaval	16	ADDRESS	1	mal	D BY KEGIS JKAK	ZSb. REGISTRAK	13 SIGNATUR	E.
25M 1/67 M. Hully W. Hully E sycesially, Ma. DATE 2 2 1967 Minutes Inda	25M 1/67	No	_/	HUNLY L	J. Hulyk	t -	Syceowell	1,	INCO. DATE	7 9 9 1967	mlin	May Q	udge

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13732 13729 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a STATE b. COUNTY Maryland Baltimore
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) MARYLAND Carroll Baltimore 24 haurs after b. CITY OR TOWN (If autside carporate limits, c. LENGTH OF STAY IN 16 n by th rs. Pag hours c write RURAL and give negrest tawn) 6 months Baltimore Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Paper The 72 elythed NO THE Springfield State Hospital 3309 Elgin YES E₃ 3. NAME OF Middle 4 DATE carbon Day Year DECEASED SOPHIA SAUER CATHERINE (Type or print) DEATH 10 cample The law requires that the death certificate be executed IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Manths Hours Days WIDOWED K DIVORCED - 28 - 80 white female and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY COUNTRY? Maryland S 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME remova unknown George L. Bents 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) (If yes give war ar dates of service) 17. INFORMANT Address 16. SOCIAL SECURITY NO ar Hospital Records 211-20-9333 no 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Generalized Arteriorsclerotic Cardio-vascular DUE TO Disease Canditions, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying cause ar attending 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO S OR ATTENDING PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (City or town) (County) (Stote) Haur a.m. While Nat While factory, street, affice bldg., etc.) at wark be retained by he deceased fram 5 = 8 , 19 67, ta 10 -26, 19 67that (1) (we) las 19 67, and that death accurred at 10: M, fram causes and an the date stated above 21. I certify that (I) (this haspital) attended the deceased fram. saw the deceased alive an 10 - 26 TO FUNERAL DIRECTOR: 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF 10-26-67 DIRECTOR PHYS. PHYS. TO HOSPITAL Page 4 may b 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) D'Alfredo M. Labbit Springfield State Hospital 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote)

New Cathedral

Baltimore

2Sb. REGISTRAR'S SIGNATUR

2So. REC'D BY 'REGISTRAR

REMOVAL (Specify)

24. FUNERAL DIRECTOR

G. Howard

Buria'

VR A15 (4) 25M 1/67

10-30-1967

Strong 3207 W. North Ave..

attention of a surface of the allies allies TERRORAN STEEL BOOK ST 10.01 08 - 03 - 7. 15 5 7. months and a second second second second 170 act (1811 left) - 27 (2-74 L) Entire the object of the sent the try the first return to Latzer what binty be , Maria de la compansión de la compansió City Court State of State Williams And O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13733

		PLACE OF DEATH			Vhere deceosed lived, if in		efore odmission)
	(o. COUNTY Carroll	MARYLAND	o. STATE Mary	land b.	COUNTY	1
	l	b. CITY OR TOWN (If outside corporate limits, c. LENGTHA	OF SIAY IN 16		tside corporote limits, writ	e RURAL ond give ne	orest town)
	S	write RURAL and give nearest tawn) ykesville, 24 yr	s./9 mos	Baltimor	e 21230		30-4
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street odd	iress)	d. STREET ADDRESS			e. IS RESIDENCE
2	S	pringfield State Hospital		1108 E.	Fort Ave.		ON A FARM? YES NO DE
	3. 1	NAME OF First M	iddle	Lost	4. DATE	Month	Doy Year
	(DECEASED (Type or print) Ruth Elair	e SCHI	WABLINE	OF DEATH OC	tober 2	1. 1967
	S. 5			DATE OF BIRTH	9. AGE (In year	ors IF UNDER 1 YEA	AR IF UNDER 24 HRS.
	f	female white WIDOWED	DIVORCED	3-13-23	last birthdo	yrs. Months Do	ys Hours Min.
		. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINE	SS OR	11. BIRTHPLACE (County	& Stote, or foreign country)		OF WHAT
		ing most of working life, even if retired) INDUSTRY		Maryland		US	
	13.	FATHER'S NAME		14. MOTHER'S MAIDEN I			
	E	Earl Schwabline		Atlantic	Jones		
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECUR	TY NO. 17. IN	IFORMANT		Address	
	(76:	(If yes give wor or dotes of service)	Sı	pringfield	State Hospi	tal Record	ds
		1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond					INTERVAL BETWEEN
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Pneumonia					ONSET AND DEATH
		493 X DUE TO					
		Conditions, if ony, which gove) (b)					
		rise to immediate cause (a), stating the underlying cause DUE TO					
		lost. (c)					
	N.	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT CBS with congenital spastic pa	NOT RELATED TO TH	IE TERMINAL DISEASE CON	DITION GIVEN IN PART I(0)	19. WAS AUTOPSY PERFORMED?
2	CATIO	Mental retardation, severe.	rabregra	wrenout qu	arriving bu	rase.	YES NO X
	CERTIFICATION		NJURY OCCURRED. (E	inter noture of injury in	Port I or Port II of item 11	B.)	
	MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURR		OF INJURY (Home, form		rn) (County)	(Stote)
	ME	Haur o.m. While Not Wh		ry, street, office bldg., etc.)	The state of the s		
		21. I certify that (I) (this haspital) attended the de	eased fram	1-5-43 ,1	9, ta10_:	21-67, 19	that (I) (we) lo
		21. I certify that (I) (this haspital) attended the desaw the deceased alive on 10-21-67 19	eased fram		9 to 10-1	2 1- 67, 19, ises ond on the o	that (I) (we) lo
		21. I certify that (I) (this haspital) attended the desaw the deceased alive on 10-21-67 19	eased fram		9 ta 10-1 4:25 M, TOM cau	21-67, 19, ises ond on the calculation 22b. DATE S	date stoted obov
		34W THE deceased diffe on	ceased fram, ond that	ATTENDING PHYS. 22d. ADDRESS	MED STAFF DIRECTOR DISTAFF PHYS. Springfield	22b. DATE S 10-2	date stoted obov SIGNED L-67
]	230	220. SIGNATURE 220. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. B. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME	ceased fram, ond that	ATTENDING PHYS. 22d. ADDRESS	MED. STAFF PHYS.	22b. DATES 22b. DATES 10-2 State Hos Maryland	date stoted obov SIGNED L-67
	230.	220. SIGNATURE 220. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME REMOVAL (Specify)	eased fram, ond that OF CEMETERY OR CO	ATTENDING PHYS. 22d. ADDRESS	MED STAFF DIRECTOR D STAFF PHYS. Springfield Sykesville, 23d. LOCATION (City	22b. DATES 22b. DATES 10-2 State Hos Maryland	date stoted obov
1		220. SIGNATURE 220. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME REMOVAL (Specify)	of CEMETERY OR CO	ATTENDING PHYS. 22d. ADDRESS	MED. STAFF DIRECTOR STAFF PHYS. Springfield Sykesville, 23d. LOCATION (City Brooklyn.	22b. DATES 22b. DATES 10-2 State Hos Maryland	date stoted oboversioned L-67 Dital 21784 (Stote)

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DIVISION OF STATISTICAL RESEA	CERTIFICAT	s, 301 W. PRESTO	N STREET, BALTIMO	DRE 1, MARYLAND
D. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) 1. PLACE OF DEATH O. COUNTY O. COUNT	MARYLAND c. LENGTH OF STAY IN 1b	o. STATE	CE (Where decessed lived, If ir b. COUNT b. COUN	CARROLL
d. NAME OF HOSPITAL OR INSTITUTION (IF not In hosp	45 YRS.		MINSTER	e. IS RESIDEN ON A FARM
CARROLL G. GEN. HOSE 3. NAME OF DECEASED (Type or print) CHARLES	Middle SE	IJ CHA Last SR.	A. DATE Month OF DEATH	Day Yes NO 1967
5. SEX MALE 6. COLOR OR RACE 7. MARRIED WHITE WIDOWED	NEVER MARRIED 8.	DEC. 11 189	93 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HR Months Deys Hours Min.
done during most of working life, even if retired)	ND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Count CARROL 14. MOTHER'S MAIDEN I		12. CITIZEN OF WHAT COUNT
LEWIS SEIPP 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. S (Yes, no, or unkown) (Ifyesgive war or dales of service)		NFORMANT	DRECHS Address	17 CHASE ST.
18. CAUSE OF DEATH [Enter only one cause per line part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	15-34-1073 / ne for (a), (b), end (c).] CARDIAC	PRS, MELUI PRREST	N I BLIZZAK	INTERVAL BETWEEN ONSET AND DEATH IMMED.
geve rise to immediate cause (e), steting the underlying DUE TO	YOCARDIAL		140	12 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONT 20e. ACCIDENT WAS UNDERLYING 20b. DESC 20c. ACCIDENT WAS UNDERLYING 20b. DESC		PRTERIO S. T RELATED TO THE TERMIN		EN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO
	CRIBE HOW INJURY OCCURED.	(Enter nature of injury in f	Part I or Pert II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 20d. If Hour e.m. While p.m. 19	Not While fector	CE OF INJURY (Home, farm ory, street, office bldg., etc.	n, 20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attends saw the deceased alive on				and on the date stated abo
226. PHYSICIAN'S NAME (Type)	as Sh M.		AED. STAFF PHYS. PHYS.	10/15/67
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 10 18/69 24 FUNERAL DIRECTOR'S SIGNATURE	23c. NAME OF CEMETERY C	CEMETE		(State) WESTMINSTER MI ISTRAR'S SIGNATURE
J. 2 mps. J. Mist	promoto,	nd oct	19 1967 gel	mes Judge

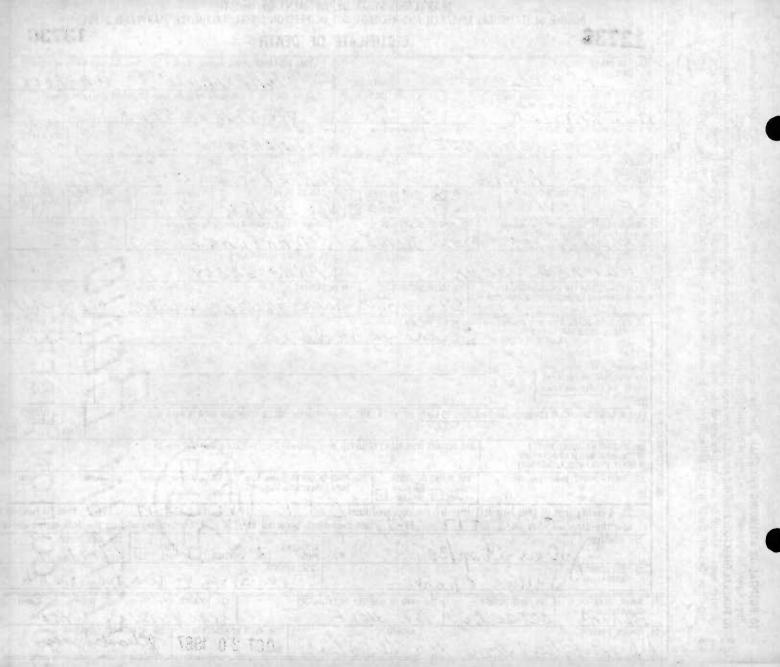
MARYLAND STATE DEPARTMENT OF HEALTH

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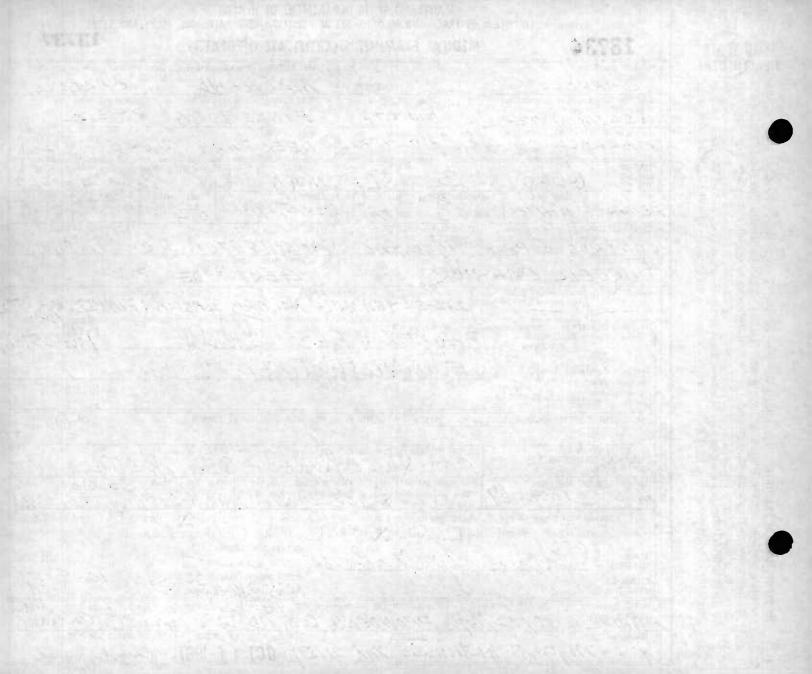
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEA 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where dereased lived if institution: Residence before admission) o. COUNTY o. STATE Alleg. Co. Page b. CITY OR TOWN (If outside corporate limits. MARYLAND CLENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Cleveland Sykesville d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE farm ON A FARM? 1421 W. 84th Street Springfield State Hospital 8. Give Pages YES NO X with 3. NAME OF Middle 4. DATE Month Lost Year Harry Allen DECEASED Shaffer October alang v (Type or print) DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED DATE OF BIRTH 9. AGE (In years NEVER MARRIED) dest birthdoy) Male Dovs Hours White 5-2-27 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Illinoise U.S.A VUD Salesman pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harry Shaffer and Edna Keeler 這 IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address be executed (Yes, no. or unknown) (If yes give wor or dotes of service) remaval. 312-22-0662 Springfield State Hosp. Records IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY 0 IMMEDIATE CAUSE (o writing the word certificate shauld crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO 9-12-67 stoting the underlying couse Communted fracture distal end of tibia and fibula left. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? YES NO certificate, p 200. EXTERNAL CAUSE WAS PRIMARY Cor CONTRIBUTING CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port or Port II of item 1B.) prior (County) 20c. TIME OF INJURY Month, Dov. Year 20e. PLACE OF INJURY (Home. (City or town) (Stote) Not While DIRECTOR: Page Sykesville Carroll ot work 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X lar Inquiry and in my apinian death resulted fram: Natural causes Accident X Hamicide Suicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funeral may be 1 DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) W. Glenn Speicher, M.D. 5 may ro FUNE Health the BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town (County REMOVAL (Specify) Cemetery Green Wood U 1-1 A FUNERAL DIRECTOR VR A15ME (5) 6M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13736 CERTIFICATE OF DEATH 24 haurs after death funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY MARYLAND ages b. CITY OR TOWN (If outside carporate limits. c. LENGTH OF STAY IN 16 E c. CITY OR TOWN (If outside corparate limits, write RURAL and give negrest town) write RURAL and give nearest town) WESTMINSTER e. IS RESIDENCE ON A FARM? popers. d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 HERSH ERSH NO X YES PHYSICIAN: The law requires that the death certificate be executed within 3. NAME OF Middle Lost DATE Month Doy Year burial, crematian, or remaval, and in any event, wit remave carban DECEASED OF DEATH OCT 196 (Type or print) S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Manths Hours Dovs WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b, KIND OF BUSINESS OR during most of working life, eyen if retired) COUNTRY? INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME NNA EARLY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. (If yes give war or dotes of service (Yes, no, or unknown) JOHN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN signed by the burial-transit ONSE AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detached far use State Dept. af Health NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work 1949 to Oct 17 _, 19<u>67</u>, that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased fram (1) be filed with the and that death accurred at 4:30 PM, fram causes and an the date stated above. 1967 saw the deceased alive an DATE SIGNED 22o. SIGNATURE ATTENDING PHYS. M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) NOODSBORO 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13737 13734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE Page 0 of death. CARROLL MARYLAND b. CITY OR TOWN (If autside carporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) and write RURAL and give nearest tawn) after MINUETS FINKSBURG WESTMINISTER d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS Prours CARROLL CO. GEN HOSPIT ON A FARM? DEER PARK Pages YES NO 3. NAME OF Middle First DATE Manth Day Year DECEASED OF (Type or print) DEATH Office alang within 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS ¥. ast hirthday) Months Days Hours MHITE WIDOWED DIVORCED event 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during mast of warking life, even if retired) INDUSTRY COUNTRY? any HOSPI Examiner's pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME = URCELL CARRICK CHERTRUDE and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, no, or unknown) (If yes give war ar dates of service) remaval, 212-52-9511MR SLASMAN FINKSRURG 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ar IMMEDIATE CAUSE shauld ward crematian, DUE TO Canditians, if any, which gave rise ta immediate couse (a). DUE TO 0 stating the underlying cause SD last. burial, 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO certificate, p 20a. EXTERNAL CAUSE WAS priar 20b. DESCRIBE HOW INJURY OCCURRED. (Eggs nature of injury in Part 1 or Page) of item 18. shauld PRIMARY OF CONTRIBUTING CAUSE OF DEATH. agent, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town Not While may be retained for yaur FUNERAL DIRECTOR: Page of wark 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X and in my apinion death resulted fram: Natural causes Suicide Hamicide Undetermined manner D edse CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE ar DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) tesun orgcounty the 23c. NAME OF CEMETERY OR CREMATORY PINKS RI 23o. BURIAL, CREMATION, 23b. DATE THEREO! (County) 50 PROUDENCE CEM 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME



MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13736 13739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 2 Maryland Carroll Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) puo Hampstead Westminster Days IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 60 Carroll County General Hospital 111 Summit, Ave YES NO X after death. NAME OF Middle 4. DATE Last Month Year ongrivith Day DECEASED (Type or print) DEATH S. SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED last birthday) Months Days Hours in pencil in Item 18. 0 White Female Dec. 18, 1902 hours ofter death WIDOWED DIVORCED This certificate should be executed within 24 hours lond2 12. CITIZEN OF WHAT 1Do. USUAL OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) **INDUSTRY** COUNTRY? Lowell, Mass U.S.A word "pending" in pencil in the Chief Medical Exominer's House-wife Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John C. Cook Mary B. Thurston 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. event within 72 (Yes, na, ar unknown) (If yes give war or dates af service) Varnan A. Snyder Hampstead. 217-12-1061 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) writing the word DUE TO any Canditians, if any, which gave rise ta immediate cause (a), forwarded to DUE TO stating the underlying cause 0 puo WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) or removal, YES X NO 20a. EXTERNAL CAUSE WAS PRIMARY 5€ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter natural of injury in Port I or Port II of item IB.) 3 should MEDICAL EXAMINER: cremation, 2De. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20f. (City or town) (County) factory, street, affice bldg., etc.) Nat While DIRECTOR: Page at wark 21. I certify that I took charge of the remains described above, held on Autopsy X, Inspection Inquiry ond in my opinion for Natural causes 1. Accident XI. death resulted from: Suicide . Hamicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE ! FUNERAL O DEPUTY DEPUTY MEDICAL EXAMINER EXAMINER'S Heolth 1 may NAME (Type) 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 0 REMOVAL (Specify) Wesley Cemetery Carrol Hampstead duria. 2Sb. REGISTRAR'S SIGNATULE ADDRESS 250 REC'D BY REGISTRAR VR A 15ME (5) 6M 1/67 Hampstead, Maryland

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CERTIFICATE OF DEATH

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	o. COUNTY	CARROLL	MARYLAND	2. USUAL RESIDENCE (Whe o. STATE Maryland	re deceosed lived, if institut b. COU		
		If outside corporate limits d give nearest tawn)	c. LENGTH OF STAY IN 16		de corporote limits, write RU		
	d. NAME OF HOSPIT	TAL OR INSTITUTION (If no	t in hospital, give street oddress)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
2	Springf	ield State	Hospital	3518 Ingles	side Ave.		YES NO
3.	NAME OF OECEASEO (Type or print)	Pir XXXXXX	ST XXXX MOLLY NM N 50	LOWESZYX 4	OF DEATH 10	th 00 26	Year 19 67
S.	female	6. COLOR OR RACE	7. MARRIEO NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH	9. AGE (In years last birthdoy) 53 yrs.	Months Ooys	
10d du	o. USUAL OCCUPATION uring most of working housewil	(Give kind of work done life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & St	tote, or foreign country)	12. CITIZEN COUNTRY	?
13	3. FATHER'S NAME	DAVID REIC		14. MOTHER'S MAIDEN NAM	ANNA RAPPAPO		
	S. WAS DECEASED EVE	R IN U.S. ARMEO FORCES? (If yes give wor or dotes o	16. SOCIAL SECURITY NO. 17		SZYK. 3518 ddr.	ÎNGLESI DE K AXAXSKA	AVE.#1
		TH WAS CAUSEO BY: IMMEDIATE CAUSE	se per line for (o), (b), ond (c).) (a) Portal Cirrhos	is	*		ITERVAL BETWEEN INSET AND OEATH INNER OWN
	Conditions, if ony rise to immediat stating the under	te couse (o), OUE	(b)				
ATION	Conditions, if ony rise to immediate stating the under lost.	te couse (o), ourlying couse	(b)	D THE TERMINAL DISEASE CONDIT	TION GIVEN IN PART 1(0)		7. WAS AUTOPSY PERFORMED? YES NO
CERTIFICATION	Conditions, if ony rise to immedial stating the under lost. PART II. OTHER SI 200. ACCIDENT WA OF CONTRIBUTING	r, which gove the couse (o), oue out of the couse (o), out out of the couse out out of the couse out	(b) TO (c)				PERFORMED?
MEDICAL CERTIFICATION	Conditions, if ony rise to immedial stoting the under lost. PART II. OTHER SI 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY) 201. TIME OF INJ Hour o.	which gove the couse (o), outlying couse (o), orlying couse outliness outlin	(b)				PERFORMED?
	Conditions, if ony rise to immediate storing the under lost. PART II. OTHER SI 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJ Hour o. p. 21.	which gove the couse (o), outlying couse (o). IGNIFICANT CONDITIONS COUNTY (O) SUNDERLYING COUNTY (O	(b)	D. (Enter noture of injury in Port LACE OF INJURY (Home, form, actary, street, affice bldg., etc.) 10–21, 19 and death accurred at 1	20f. (City or town)	(County)	PERFORMED? YES NO (Stote)
	Conditions, if ony rise to immediate storing the under lost. PART II. OTHER SI 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJ Hour o.). 21. I certical saw the decrease of the contribution of the contri	which gove the couse (o), outlying couse (o). IGNIFICANT CONDITIONS COUNTY (O) SUNDERLYING COUNTY (O	(b)	D. (Enter noture of injury in Port PLACE OF INJURY (Home, form, actory, street, affice bldg., etc.) 10-21, 19 at death accurred at 1 ATTENDING ME OIR	20f. (City or town) 67. ta 10 26	(County) 5, 1967, t and an the da	PERFORMED? (Stote) that (I) (we) I
	Conditions, if ony rise to immediate storing the under lost. PART II. OTHER SI 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJ Hour o.). 21. I certical saw the decrease of the contribution of the contri	SUNDERLYING DESCRIPTIONS CONTINUES OF DEATH MEDICAL EXAMINER) URY Month, Ooy, Yeorm. 19 Ify that (I) (this has eceased alive an	(b)	D. (Enter noture of injury in Port PLACE OF INJURY (Home, form, actory, street, affice bldg., etc.) 10-21, 19 act death accurred at 1 ATTENDING ME PHYS. OR	20f. (City or town) 20f. (City or town) 67, ta 10 26 M, fram causes D. STAFF	(County) 3 19 67 t and an the da 22b. OATE SIG	PERFORMED? YES NO (Stote) that (I) (we) the stated above.
MEDICAL	Conditions, if ony rise to immediate storing the under lost. PART II. OTHER SI 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJ Hour o. p. 21. I certi saw the d 220. SIGNATURE 22c. PHYSICIAN'S	Which gove the couse (o), orlying couse (o), orlying couse (o), orlying couse (o). SUNDERLYING THE COUSE OF DEATH MEDICAL EXAMINER) URY Month, Coy, Yeor m. 19 Ify that (I) (this has eceased alive an the couse of the couse o	(b)	D. (Enter noture of injury in Port PLACE OF INJURY (Home, form, actory, street, affice bldg., etc.) 10-21, 19 act death accurred at 1 ATTENDING ME PHYS. OR	20f. (City or town) 20f. (City or town) 67. ta 10 26 0. RM, fram causes D. STAFF RECTOR PHYS. C 1d State Hos 23d. LOCATION (City or To	(County) 5 , 19 67 t and an the da 22b. OATE SIG	PERFORMED? YES NO (Stote) Chat (I) (we) the stated about the stated abou

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours ofter death. Page 4 may be retained by the hospital or ottending physician.

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Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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2.000		CERTIFICA	AIL OF DEATH			19441
PLACE OF DEATH O. COUNTY	ARROLL	MARYLAN	2. USUAL RESIDENCE (a. STATE Mary:		f institution: Resident Frederic	
b. CITY OR TOWN (write RURAL and	f autside carparate limits, give nearest tawn)	c. LENGTH OF STAY IN 16		utside carparate limits, s	write RURAL and giv	ve nearest tawn)
d. NAME OF HOSPIT		in haspital, give street address)	d. STREET ADDRESS	- 1		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	Firs WILBU		SPEAKE	4. DATE OF DEATH	Manth 10/	Day Year 25 19 67
s. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED NOT NEVER MARRIED	8. DATE OF BIRTH 5/2/98	9. AGE (In last birt	thday) Manths yrs.	Days Haurs Min.
during mast of warking None	(Give kind af wark dane life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	Freder	& State, ar fareign count	12. C	ITIZEN OF WHAT DUNTRY? U.S.A.
	I. Speake			Jane Derr		
15. WAS DECEASED EVE (Yes, na, ar unknawn)	R IN U.S. ARMED FORCES? (If yes give war ar dates af	16. SOCIAL SECURITY NO.	17. INFORMANT Springfie	ld State He	Address ospital F	lecords
	ATH (Enter only one cause TH WAS CAUSED BY: IMMEDIATE CAUSE (c					INTERVAL BETWEEN ONSEL AND DEATH
Canditians, if any rise to immediat stating the unde last.	e cause (a), rlying cause	Uremia Generalized art				days
CBS a. 20a. ACCIDENT WAY OR CONTRIBUTING	ssoc. with d	NTRIBUTING TO DEATH BUT NOT RELATED CONVULSIVE DISORDER 20b. DESCRIBE HOW INJURY OCCUR	r without qua	lifying ph	rase	19. WAS AUTOPSY PERFORMED? YES NO
	JRY Manth, Day, Year	20d. INJURY OCCURRED 20e While Nat While at wark at wark	e. PLACE OF INJURY (Hame, farr factory, street, affice bldg., etc.		tawn) (Co	ounty) (State)
21. I certi	fy that (I) (this hasp eceased alive on	ital) attended the deceased fra 20/25/ 19 <u>67</u> , and	m5/10/25 , thot death accurred at	19to10, 7:35#M, from (causes and on t	
22a. SIGNATURE	_sisha	Ozem .	M.D. ATTENDING PHYS.	MED. STA	IFF FT 70	DATE SIGNED D/25/67
22c. PHYSICIAN'S NAME (Type	Suha Ozg	gun, M. D.	22d. ADDRESS Springf	ield State	Hospital	L
23a. BURIAL, CREMATION REMOVAL (Specify Burnal	10/28/6	57 St. Johns	Cometery	23d. LOCATION (C	rstown	(County) (State) Fred. md.
24. FUNERAL DIRECTO	Barlo	n Walker	MC HOOD PART	3 0 1967	25b. REGISTRAR'S	Judge.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) P.M.3. Page Department of and 3 to form in pencil in Item 18. Give Pages 1, 0 the Sta necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pac the funeral directar. Page 4 should be farwarded ta the Chief Medical Examiner's Office along with pages land 2 with in any event within 72 hours after death.

delay is

This certificate shauld be executed within 24 haurs after death.

MEDICAL EXAMINER:

TO DEPUTY

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permit. File

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Health priar ta burial, cremation, ar remaval, and 5 may be retained far yaur files.

TO FUNERAL DIRECTOR: Page 3 shauld be used as

FUNERAL DIRECTOR

	arroll		MARYL		Ma	ryland	b. COUNT	CALLO	11
b. CITY OR TOWN	(If outside carporate limit nd give neorest town)	s, c.	LENGTH OF STAY IN	lb c. Ci	TY OR TOWN (If ou	itside carporote limit	s, write RURAL	and give nearest	town)
S.	vkesville	GU + J	Life			Sykesvil	le		06-1
d. NAME OF HOSP	ITAL OR INSTITUTION (If no	ot in hospitol, give	street oddress)	d. S	TREET ADDRESS			e	e. IS RESIDENCE ON A FARM?
Rai	lroad Yard,	Sykesvil	le. Md.		Svkesvil	le, Maryl	and)	YES NO
3. NAME OF		rst	Middle		Lost	4. DATE	Month	Doy	Уеаг
(Type or print)	BEN	JAMIN	PEYTON	SUL	LIVAN	OF DEATH	Octob	er 29	19 67
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. DAT	E OF BIRTH	9. AGE (In yeors	IF UNDER 1 YEAR	IF UNDER 24 HRS
Male	White	WIDOWED _	DIVORCED	- oct	, 30, 19	17	oirthdoy) A	Months Doys	Hours Min.
10o. USUAL OCCUPATION during most of working	ON (Give kind of work done	10b. KIND (OF BUSINESS OR	11.	BIRTHPLACE (Stote	or foreign country)		12. CITIZEN OF COUNTRY?	WHAT
LADOR			ood		Md.			U.S. 1	4,
13. FATHER'S NAME				14.	MOTHER'S MAIDEN	VAME			
UNK	now N				EMMA	CLARK			
15. WAS DECEASED EN	/ER IN U.S. ARMED FORCES? (If yes give wor or dotes	16. SOCI	AL SECURITY NO.	17. INFOR	MANT	^	Address	-	
YES	111. W. Z	L	7	MRS	- Helen	DU JA	11-5	ykesu.	Ille M
	DEATH (Enter only one cou	use per line for (a),	(b), and (c).)					INTE	RVAL BETWEEN
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE	(o) Arte	riosclero	otic Ca	rdiovasc	ular Dise	ase	ONS	SET AND DEATH
722	DUE								
Conditions, if on		(b)							
rise to immedia		TO							
lost.)	(c)							
PART II. OTHER	SIGNIFICANT CONDITIONS C	ONTRIBUTING TO D	EATH BUT NOT RELA	TED TO THE TE	MINAL DISEASE CON	DITION GIVEN IN PA	RT I(o)	19.	WAS AUTOPSY PERFORMED?
ATIO									ES X NO
200. EXTERNAL (PRIMARY Or C CALISE OF DEATH		20b. DESCRI	BE HOW INJURY OC	CURRED. (Enter	noture of injury in	Port I or Port II of i	tem 1B.)		
	JURY Month, Doy, Year				NJURY (Home, farm		or town)	(County)	(State)
Hour o	.m. 19	While of work	Not While of work	toctory, str	eet, office bldg., etc.)				
21. I certi	fy that I toak chorg			ave, held on	Autopsv X	Inspection]. Inquir	y 🔲 , and	in my opinio
death resu		al causes X	Accident .	Suicide [7. Hamicide		mined man		,
	1	11-1			CHIEF MEDICAL				
SIGNATURE	duous.	to MIRO	~	M.D	ASSISTANT MED	ICAL EXAMINER		2	22. DATE SIGNED
EXAMINER'S	101				DEPUTY MEDICA				
NAME (Type)	Edward	F. Wilson	n, M.D.		Address (Street	, city, town, or coun	ty) Oc	ctober 3	0, 1967
230. BURIAL, CREMAT		EREOF 2	3c. NAME OF CEMET	and the same of		23d. LOCATION	, ,) (County)	
BREMOVAL Speci	11 11-1-	67	BALto. A	JATIONA	1	BALTI	MORE		Md

ADDRESS

2So. REC'D BY REGISTRAR

2Sb. REGISTRAR'S SIGNATURE

AND THE RESIDENCE OF THE PARTY y was vii a hall governous tracks and a subtree of the two times Valous Alanta MCCTO MISSISSI Cotaber St. 1967 The second of th

CERTIFICATE OF DEATH
1. PLACE OF DEATH a. COUNTY CARROLL GO, MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown) WEETT MINGTER d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3. NAME OF DECEASED (Typa or print) WINFELD SCOTT SULLUAN DEATH OCT SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED NEV
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Hyasgiveward aless of service) 2/2-0/-8714 MRS W. SCOTT SULLIVAN NESTMINSTER M 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Medical examiners 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 Whila Not Whila at work at work at work at work at work at work 21. I certify that (I) (this hospital) attended the deceased from 19. 19.

MARYLAND STATE DEPARTMENT OF HEALTH

CARROLL ON SHEET MARKERY) CREEKLY WEELTMINGTERS SHEEKS - WESTMINGTER RINT CAPROLL CO. GENERAL HEIMTPL. (FRIZEUSEINE) WINFIELD SCOTT SULLIGHM CCT, 24 67 18 7881 8 200 - 24W 37WW PERSONAL FLOWS MILL AND DAILEY PLEASANT VELLEY MD. U.S. EL. GNOHIMMEL ANAL ANAL MONTHER LEMMEREND 212-01-874 MAS H SOUTH SULLIFORN, NESTMINESTER INF Comment of the grown 4 miles 15 10 10/6 11/22/01 JOHN S. HARSHEY M. O. Streeten St. Worken the wil. STORE IST THE MEMORY PRINCE COME TELL NETTHINGTER ME J. E. Mardons, Ja , Continuedte met 801 3 1 1881 Charles more

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

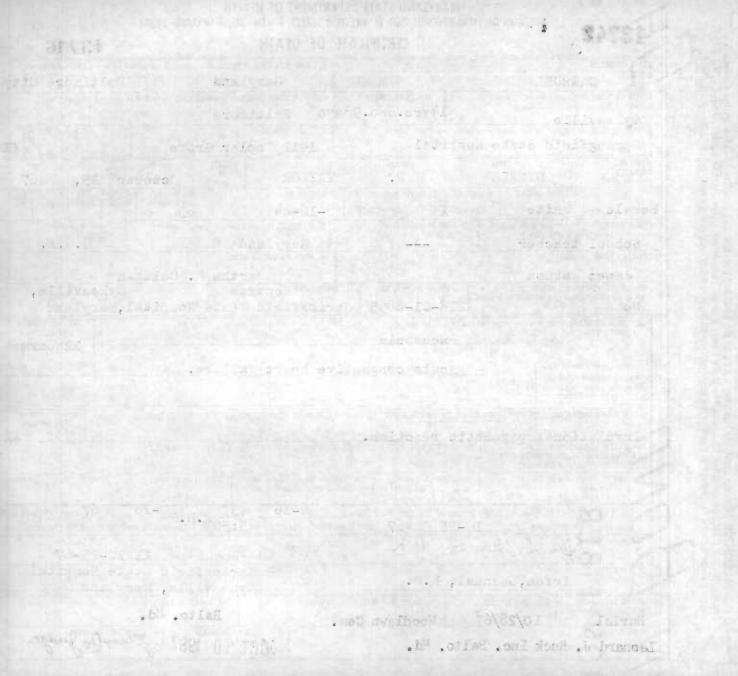
CERTIFICATE OF DEATH

13746

1. PLACE OF DEATH		2. USUAL RES	IDENCE (Where deceosed		idence before odmission)/
a. COUNTY CARROLL		AARYLAND O. STATE	Maryland	b. COUNTY BE	ltimore City
b. CITY OR TOWN (If outside corporc	te limits, c. LENGTH OF ST	AY IN 15 C. CITY OR TO	WN (If outside corporate		
write RURAL and give nearest to	14yrs.6	mo.9days B	altimore		30 4
d. NAME OF HOSPITAL OR INSTITUTION	N (If not in hospital, give street address)	d. STREET AD	DRESS		e. IS RESIDENCE
Springfield S	tate Hospital	1411	Poplar Gr	ove	ON A FARM? YES NO XOX
3. NAME OF DECEASED (Type or print) MI	First Middle NNIE R.	TAYLOR	4. DATE OF DEATH	Month October	25, 1967
S. SEX 6. COLOR OR R Female White	ACE 7. MARRIED NEVER MAR WIDOWED DIVO			ast birthdoy) Mont	DER I YEAR IF UNDER 24 HRS. Doys Hours Min.
10o. USUAL OCCUPATION (Give kind of wo during most of working life, even if retired School teache) INDUSTRY		E (County & Stote, or foreig		COUNTRY?
13. FATHER'S NAME	b		MAIDEN NAME		0.000
James Watson		ALCOHOLD STAN	Martha R	. Coleman	
IS. WAS DECEASED EVER IN U.S. ARMED F		O. 17. INFORMANT R	ecords		kesville,
(Yes, no, or unknown) (If yes give wor o	dotes of service) 218-01-885		eld State		
1B. CAUSE OF DEATH (Enter only	one couse per line for (o), (b), and (c).)	// -		,	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED	CAUSE (o) Pneumonia	9			ONSET AND DEATH
4341	DUE TO				12hours
Conditions, if ony, which gove	(b) Acute co	ngestive hea	rt failure		
rise to immediate cause (o), (stating the underlying cause (DUE TO				
lost.	(c)				
0	TIONS CONTRIBUTING TO DEATH BUT NOT		SEASE CONDITION GIVEN I	N PART 1(o)	19. WAS AUTOPSY PERFORMED? YES NO
Involutional 200. ACCIDENT WAS UNDERLYING	psychotic reaction	Y OCCURRED. (Enter noture of	injury in Part I or Part II	of item 18)	YES NO NO
OR CONTRIBUTING CAUSE OF DEAT	H	T OCCORRED. (Ellies Holbie of	injury in roll i or roll in	or nem 10.	
(IF EITHER, NOTIFY MEDICAL EXAMINE 20c. TIME OF INJURY Month, Doy,		20e. PLACE OF INJURY (H	ome, form. 20f. (City or town)	(County) (State)
20c. TIME OF INJURY Month, Doy, Hour o.m. p.m.	19 While Not While of work at work	foctory, street, office	bldg., etc.)		
	is haspital) attended the deceas	ed from 4-1		10-25	19 <u>67</u> , that (I) (we) lost
saw the deceased alive	on 10-25 1967	_, and that death accu	rred at <u>5:50</u> M, 1		n the date stated obove.
220. SIGNATURE Thou I	Mendal M.S.	M.D. PHYS.	MED. DIRECTOR	STAFF XX 10	DATE SIGNED 0-25-67
22c. PHYSICIAN'S	7 17 11 5	22d. ADD	RESS Springf	ield State	Hospital
NAME (Type) Irfan	,Esendal, M.D.		Sykesvi	lle, Mary	Land
PEMOVAL (Specify)		CEMETERY OR CREMATORY	. 23d. LOCA Bal	TION (City or Town)	(County) (Stote)
24. FUNERAL DIRECTOR	ADDRESS	MAI OGINA	2So. REC'D BY REGISTRAR		S SIGNATURE
Leonard J. Ruck	Inc. Balto. Md.		WACT 30 1		Her Judges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital ar attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campretely filled in by the directar, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after VR A15 (4) 25M 1/67



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funeral plnods thin 24 hours after in by the f The law requires that the death certificate be executed attending physician and compl director, page 3 should be detached for use as the burial, cremation, or removal, and in any event, within be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within After this certificate has been signed by the he hospital or attending physician. PHYSICIAN: ATTENDING be retained by ECTOR:

TO HOSPITA death. Page TO FUNERAL

VR A15 (4) 1SM 7/61

CERTIFICATE OF DEATH 19711

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND TRYAR

1. PLACE OF DEAT						CE (Where dec	eased lived, If i			e edmission)
Ca	rroll		MARYLANI	e. STA	^t Mai	ryland	b. COUN	14	-	
	(if outside corporete limits ad give nearest town)	s, c. LENC	OTH OF STAY IN	b c. CITY	OR TOWN	If outside corpo	rete limits, write	RURAL end g	ive neerest t	own)
Westmin	ster				Bal	Ltimore				30-4
	PITAL OR INSTITUTION (H			d. STRE	ET ADDRESS					RESIDENCE N A FARM?
	1 County Ger	neral Hosp	ital	4	1132 Pa	arkside	Drive		YES [
3. NAME OF DECEASED	First		Middle	La	st	4. DATE OF	Month		Dey Y	eer
(Type or print)	LULA	M		UNGER		DEATH	Octobe			9 67
5. SEX	6. COLOR OR RACE	7. MARRIED X NE	VER MARRIED	8. DATE OF B		9.	AGE (In years last birthday)	Months De		
Female	White	WIDOWED [DIVORCED	Jan. 3,			59 yrs.			
done during most of w	TION (Give kind of work rorking life, even if retired	10b. KIND OF BI	USINESS OR INDU				oreign country)			T COUNTRY?
At home					ryland				U.S.A.	•
13. FATHER'S NAME	m Pools				R'S MAIDEN					
Willia						Bettien				1
(Yes, no, or unkown)	VER IN U.S. ARMED FOR ((If yes give wer or detes of se	rvice) 16. SOCIAL S		7. INFORMAN			Address		-	
				Elliott	F. W.	unger,	4132 Pa	irkside	-	
	TH WAS CAUSED BY:	cause per line for (a)	, (b), end (c).]						ONSET AN	
	IMMEDIATE CAUSE (a)_									
4201	DUE TO	1.		11	,				7.4	
Conditions, if en	(1)_	Coro	many 1	non	bose.				9 0000	× _
(e), steting the cause lest.	DIE TO	athero	schrote	· Hear	t Due	nae			3 your	~
Z PART II. OTH	ER SIGNIFICANT CONDIT						ONDITION GIV	EN IN PART 1(AUTOPSY
ĬĘ									YES T	FORMED?
OR CONTRIBUTING	MAS UNDERLYING COME CAUSE OF DEATH Y MEDICAL EXAMINER)	2Db. DESCRIBE HO	W INJURY OCCU	IRED. (Enter natur	e of injury in	Pert I or Pert II	of item 1B.)			
3 20c. TIME OF INJ	JURY Month, Day, Yee			PLACE OF INJUR			or town)	(County)	(Stete)
20c. TIME OF INJ Hour a.m.	19		While work	factory, street, of	ice bidg., etc.	•) }				
	that (I) (this hospital	al), attended the	deceased fro	m /0/21		1967 to	10/24	. 196) that (1)	(we) last
saw the decea	ased alive on/	1/24 1	9.67., and 1	hat death occ	cured ai?	p.M. from	the causes	and on the	date sta	ted above
22e. SIGNATURE	-5. Hara	hy		M.D. ATTENI	4	MED.	STAFF PHYS.	101	24/6.	2b. DATE SIGNED
NAME (Typ	5	S. HARS	HEY M	D 80	nelu	_st	West		, med	
23a. BURIAL, CREMA	TION, 236. DATE THER		AME OF CEMETE	RY OR CREMATO	ORY	23d. LOCA	TION (City, tow	vn or county)		(Stete)
Burial Specific	10/28/6	7 Bal	timore C	emetery	E 1.27	Balti	more, M	d.		
24 FUNERAL DIRECTO	OR'S SIGNATURE		DDRESS			C'D BY REGISTI	AR 256. REC	SISTRAR'S SIG		
Ullrich 1	Funeral Home	4210 Bel	air Road		DATE	DET 27	1967	Jelian	cas yeu	The same

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13749 CERTIFICATE OF DEATH 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE COUNTY 9710/1 MARYLAND and in ony event, within 72 hours ofter c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN corporate limits, write RURAL and give nearest town) write RURAL and give nearest town month 3 filled in b d. STREET ADDRESS B. IS RESIDENCE INSTITUTION (If not in hospital, give street address) ON A FARM? YES NO low requires that the deoth certificate be executed within 3. NAME OF 4 DATE Year Month Doy DECEASED TY9Ce 196 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years lost birthday) Months Days Hours Jan 22 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) INDUSTRY during most of working life, even if retired) COUNTRY? House wilo County 14. MOTHER'S MAIDEN NAM 13. FATHER'S NAME or removal, Hocksdale amin IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, no, or upknown) ((If yes give wor or dotes of service) Owings Mills cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) be retained by the hospitol or ottending physician. DUF TO burial, Conditions, if ony, which gove rise to immediate couse (a). DUF TO for use os the b f Heolth prior tab stoting the underlying couse this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER Stote Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work O FUNERAL DIRECTOR: After 1967, that ((we) lost 21. I certify that (1) (this hospital), ottended the deceased from ond that death occurred at 7:45 AM, from couses and on the date stated above. sow the deceosed olive on 22b. DATE-SIGNED 220. SIGNATURE ATTENDING director, poge 3 should be filed v M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Poge 4 may NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) YEADON BRANCH 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

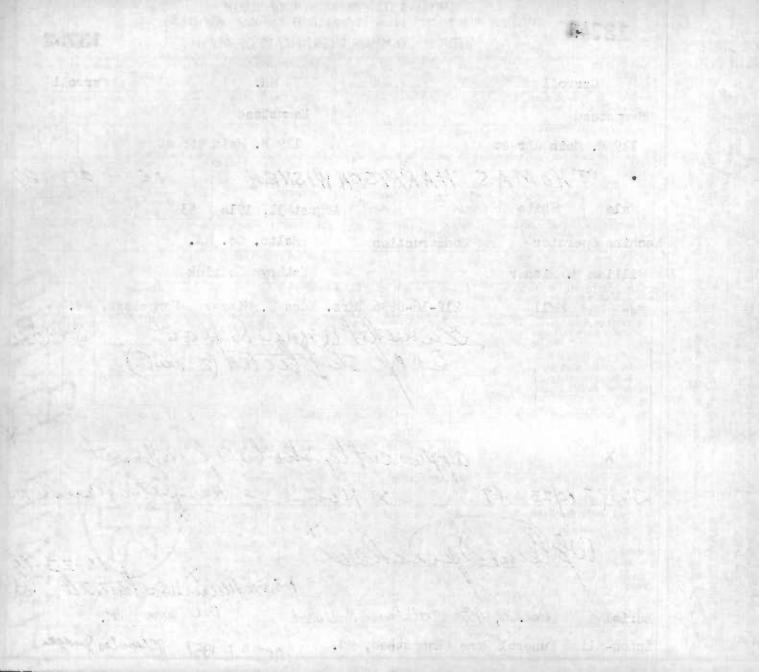
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Carroll MARYLANO delay b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give neorest tawn) Hampstead Hampstead e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitof, give street oddress) d. STREET ADORESS torm 119 N. Main Street 119 N. Main Street 0-0 NO X This certificate shauld be executed within 24 hours ofter deoth. 3. NAME OF Middle 4. DATE First Month Year DECEASED 0F in pencil in Item 18. Give (Type or print) DEATH S. SEX IF LINOER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 7. MARRIEO NEVER MARRIED 53 birthdoy) Months Hours Min. White Male August 31, 1914 File pages 1 and 2 w 2 hours ofter death WIOOWEO DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Machine Operator Construction COUNTRY? Balto. Co. Md. 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME Kathryn Hedrick William H. Wisner 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) within 212-16-0996 Mrs. Edna E. Wisner Hampstead, Md. Yes 18. CAUSE OF DEATH (Enter only one couse per line for(a), (b), and (c). INTERVAL BETY buriol-transit event PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). writing the word **OUE TO** ony Conditions, if ony, which gove forworded to rise to immediate couse (o), = DUE TO stoting the underlying couse 0 05 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) or removol, CERTIFICATION the certificate, NO YES pe 20o. EXTERNAL CAUSE WAS PRIMARY DO OF CONTRIBUTING ☐ CAUSE OF DEATH. should EXAMINER: cremotion, 20c. TfME OF INJURY Month, Doy, Year 20d NUURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town (Stote) factory, street, office blda., etc. Not While of work please execute 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X and in my apinian Inquiry Suicide X death resulted from: Natural causes Accident Hamicide Undetermined manner retoined CHIEF MEDICAL FXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER prior SIGNATURE FUNERAL I DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY Baltimore 23o. BURIAL CREMATION (County) 50 Burial (Specify) Baltimore National Oct. 26. 24 FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR Ocharles Judges VR A15ME Tipton-Eline Funeral Home Hampstead, Md.



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